UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF NEW YORK

In re Absolut Facilities Management, LLC, *et al.*
Debtor

Case No. 19-76260 (AST) (Jointly Administered)
Federal Tax I.D. # 20-8471412

INITIAL MONTHLY OPERATING REPORT

File report and attachments with Court and submit copy to the United States Trustee within 10 days after order for relief

Certificates of insurance must name United States Trustee as a party to be notified in the event of policy cancellation. Bank accounts and checks must bear the name of the debtor, the case number, and the designation "Debtor-in-Possession". Examples of acceptable evidence of debtor-in-possession bank accounts include voided checks, copy of bank deposit agreement/certificate of authority, signature card and/or corporate checking resolution.

REQUIRED DOCUMENTS	Document Attached	Explanation Attached
12-Month Cash Flow Projection (Form IR-1)	X	
Certificates of Insurance:	X	
Workers Compensation	X	
Property	X	
General Liability	X	
Vehicle	X	
Other:		
Evidence of Debtor in Possession Bank Accounts	X	
Tax Escrow Account		
General Operating Account		
Other:		
Other:		

I declare under penalty of perjury (28 U.S.C. Section 1746) that this report and the documents attached are true and correct to the best of my knowledge and belief.

Signature of Debtor — Date

Signature of Joint Debtor — Date

Signature of Authorized Individual* — Date: 10/21/2019

Mike Wyse — Printed Name of Authorized Individual

CRO — Title of Authorized Individual

*Authorized individual must be an officer, director or shareholder if debtor is a corporation; a partner if debtor is a partnership; a manager or member if debtor is a limited liability company.

United States Trustee
Initial Reporting Requirements Documents

Attachment B - Insurance Expiration Statement

Coverage/Property Description	Insurance Type & Property Insured	Agent/Contact	Expiration	Paid Through	Policy Limits
Property	Allegany Aurora Park Gasport Orchard Brooke Orchard Park Three Rivers Westfield	Michael Schwimmer Grandview Brokerage, Inc. 1815 65th St, Brooklyn NY 11204 t 718.333.1155 x 5001	8.9.20	8.9.20	1,000,000
General Liability / Professional	Allegany Aurora Park Gasport Orchard Brooke Orchard Park Three Rivers Westfield	Michael Schwimmer Grandview Brokerage, Inc. 1815 65th St, Brooklyn NY 11204 t 718.333.1155 x 5001	9.8.20	9.8.20	1,000,000/3,000,000
Workers Comp	Allegany Aurora Park Gasport Orchard Brooke Orchard Park Three Rivers Westfield	Michael Schwimmer Grandview Brokerage, Inc. 1815 65th St, Brooklyn NY 11204 t 718.333.1155 x 5001	5.1.20	5.1.20	1,000,000
NYS Disability	Allegany Aurora Park Gasport Orchard Brooke Orchard Park Three Rivers Westfield	Michael Schwimmer Grandview Brokerage, Inc. 1815 65th St, Brooklyn NY 11204 t 718.333.1155 x 5001	12.31.20	12.31.20	
Crime	Allegany Aurora Park Gasport Orchard Brooke Orchard Park Three Rivers Westfield	Hayli Dunn **TIS Insurance Services, Inc.** 1900 N. Winston Road, Suite 100 Knoxville, TN 37919	3.15.20	3.15 20	500,000
Surety Bond	Allegany Aurora Park Gasport Orchard Brooke Orchard Park Three Rivers Westfield	Hayli Dunn **TIS Insurance Services, Inc.** 1900 N. Winston Road, Suite 100 Knoxville, TN 37919	2.1.20	2.1.20	25,000 140,000 30,000 45,000 100,000 30,000 30,000
Auto - transport Auto - cars	Allegany Aurora Park Gasport Orchard Brooke Orchard Park Three Rivers Westfield	Michael Schwimmer Grandview Brokerage, Inc. 1815 65th St, Brooklyn NY 11204 t 718.333.1155 x 5001	3.1.20 8.9 20	3.1.20 8.9.20	1,000,000 1,000,000
EPLI	Allegany Aurora Park Gasport Orchard Brooke Orchard Park Three Rivers Westfield	Michael Schwimmer Grandview Brokerage, Inc. 1815 65th St, Brooklyn NY 11204 t 718.333.1155 x 5001	8.24.20	8.24.20	1,000,000
Umbrella	Allegany Aurora Park Gasport Orchard Brooke Orchard Park Three Rivers Westfield	Michael Schwimmer Grandview Brokerage, Inc. 1815 65th St, Brooklyn NY 11204 t 718.333.1155 x 5001	9.8.20	9.8.20	5,000,000/5,000,000

I declare under penalty of perjury that the information provided above and on any attachments hereto is true and correct to the best of my knowledge and belief.

9/23/19 — Date:

[signature] — Signature

Philip Hoffman, Interim CFO — Printed name & title

Mattucci, Lisa

From: Mattucci, Lisa
Sent: Friday, September 20, 2019 6:29 AM
To: Isaac Kleinman (Ikleinman@gvwins.com); Grandview Brokerage (rockoven@gvwins.com)
Cc: Michael Schwimmer (michael@gvwins.com); Sherman, Israel; Hoffman, Phil
Subject: Absolut Insurance

Importance: High

Hi all,

We are required to add to each insurance policy: "United States Trustee" as an additional notified party – not to list as additional loss payee.

I unfortunately need this today please.

Property, GL PL, EPLI, WC, DBL, Auto.

Thank you,
Lisa

NROCKOVE

ACORD

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY) 6/11/2019

THIS EVIDENCE OF COMMERCIAL PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

PRODUCER NAME, CONTACT PERSON AND ADDRESS	PHONE (A/C, No, Ext):	COMPANY NAME AND ADDRESS	NAIC NO:
Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204 Contact name:	(718) 333-1155	Great American Insurance Comp	
FAX (A/C, No):	E-MAIL ADDRESS:	IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	
CODE:	SUB CODE:	POLICY TYPE	
AGENCY CUSTOMER ID #: ABSOFAC-01		Property	
NAMED INSURED AND ADDRESS Absolut Center for Nursing and Rehabilitation at Allegany, LLC Absolut at Allegany 2178 North Fifth Street Allegany, NY 14706		LOAN NUMBER	POLICY NUMBER: MAC457352310
		EFFECTIVE DATE: 6/7/2019	EXPIRATION DATE: 8/9/2020 ☐ CONTINUED UNTIL TERMINATED IF CHECKED
ADDITIONAL NAMED INSURED(S)		THIS REPLACES PRIOR EVIDENCE DATED:	

PROPERTY INFORMATION (ACORD 101 may be attached if more space is required) ☒ BUILDING OR ☒ BUSINESS PERSONAL PROPERTY

LOCATION / DESCRIPTION
2178 NORTH FIFTH STREET, Allegany, NY 14706, Absolut Center at Allegany

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION PERILS INSURED ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ 104,189,254 DED: 5,000

	YES	NO	N/A				
☒ BUSINESS INCOME ☐ RENTAL VALUE	X			If YES, LIMIT:	15,863,032	Actual Loss Sustained; # of months:	
BLANKET COVERAGE	X			If YES, indicate value(s) reported on property identified above: $	4,245,434		
TERRORISM COVERAGE			X	Attach Disclosure Notice / DEC			
IS THERE A TERRORISM-SPECIFIC EXCLUSION?			X				
IS DOMESTIC TERRORISM EXCLUDED?			X				
LIMITED FUNGUS COVERAGE			X	If YES, LIMIT:		DED:	
FUNGUS EXCLUSION (If "YES", specify organization's form used)			X				
REPLACEMENT COST	X						
AGREED VALUE	X						
COINSURANCE		X		If YES, %			
EQUIPMENT BREAKDOWN (If Applicable)	X			If YES, LIMIT:	4,075,099	DED:	5,000
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg	X			If YES, LIMIT:	4,075,099	DED:	5,000
- Demolition Costs	X			If YES, LIMIT:	1,000,000	DED:	5,000
- Incr. Cost of Construction	X			If YES, LIMIT:	1,000,000	DED:	5,000
EARTH MOVEMENT (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
FLOOD (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
WIND / HAIL INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
NAMED STORM INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS							

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

☐ CONTRACT OF SALE ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE ☐ MORTGAGEE

NAME AND ADDRESS

Absolut Center for Nursing and Rehabilitation at Allegany, LLC
2178 North Fifth Street
Allegany, NY 14706

LENDER SERVICING AGENT NAME AND ADDRESS

AUTHORIZED REPRESENTATIVE

NROCKOVE

ACORD

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY) 6/11/2019

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PRODUCER NAME, CONTACT PERSON AND ADDRESS Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204 Contact name:	PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): E-MAIL ADDRESS: CODE: SUB CODE: AGENCY CUSTOMER ID #: ABSOFAC-01
COMPANY NAME AND ADDRESS Great American Insurance Comp IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	NAIC NO: POLICY TYPE: Property
NAMED INSURED AND ADDRESS Absolut Center for Nursing and Rehabilitation at Aurora Park, LLC Absolut at Aurora Park 292 Main Street East Aurora, NY 14052	LOAN NUMBER POLICY NUMBER: MAC457352310 EFFECTIVE DATE: 6/7/2019 EXPIRATION DATE: 8/9/2020 ☐ CONTINUED UNTIL TERMINATED IF CHECKED
ADDITIONAL NAMED INSURED(S)	THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION (ACORD 101 may be attached if more space is required) ☒ BUILDING OR ☒ BUSINESS PERSONAL PROPERTY

LOCATION / DESCRIPTION
292 MAIN STREET, East Aurora, NY 14052, Absolut Center at Aurora Park

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION

PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ 104,189,254 DED: 5,000

	YES	NO	N/A				
☒ BUSINESS INCOME ☐ RENTAL VALUE	X			If YES, LIMIT:	15,863,032	Actual Loss Sustained; # of months:	
BLANKET COVERAGE	X			If YES, indicate value(s) reported on property identified above: $			44,157,206
TERRORISM COVERAGE	X			Attach Disclosure Notice / DEC			
IS THERE A TERRORISM-SPECIFIC EXCLUSION?			X				
IS DOMESTIC TERRORISM EXCLUDED?			X				
LIMITED FUNGUS COVERAGE			X	If YES, LIMIT:		DED:	
FUNGUS EXCLUSION (If "YES", specify organization's form used)			X				
REPLACEMENT COST		X					
AGREED VALUE	X						
COINSURANCE	X			If YES, %			
EQUIPMENT BREAKDOWN (If Applicable)	X			If YES, LIMIT:	43,124,775	DED:	5,000
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg		X		If YES, LIMIT:	43,124,775	DED:	5,000
- Demolition Costs	X			If YES, LIMIT:	1,000,000	DED:	5,000
- Incr. Cost of Construction	X			If YES, LIMIT:	1,000,000	DED:	5,000
EARTH MOVEMENT (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
FLOOD (If Applicable)		X		If YES, LIMIT:		DED:	
WIND / HAIL INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
NAMED STORM INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS							

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

☐ CONTRACT OF SALE ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE
☐ MORTGAGEE

NAME AND ADDRESS

Absolut Center for Nursing and Rehabilitation at Aurora Park, LLC
292 Main Street
East Aurora, NY 14052

LENDER SERVICING AGENT NAME AND ADDRESS

AUTHORIZED REPRESENTATIVE

Michael Schumacher

ACORD 28 (2016/03)

NROCKOVE

ACORD

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY) 6/11/2019

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PRODUCER NAME, CONTACT PERSON AND ADDRESS Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204 Contact name:	PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): E-MAIL ADDRESS: CODE: SUB CODE: AGENCY CUSTOMER ID #: ABSOFAC-01
COMPANY NAME AND ADDRESS Great American Insurance Comp IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	NAIC NO: POLICY TYPE: Property
NAMED INSURED AND ADDRESS Absolut Center for Nursing and Rehabilitation at Gasport, LLC Absolut at Gasport 4540 Lincoln Drive Gasport, NY 14067	LOAN NUMBER POLICY NUMBER: MAC457352310 EFFECTIVE DATE: 6/7/2019 EXPIRATION DATE: 8/9/2020 ☐ CONTINUED UNTIL TERMINATED IF CHECKED
ADDITIONAL NAMED INSURED(S)	THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION (ACORD 101 may be attached if more space is required) ☒ BUILDING OR ☒ BUSINESS PERSONAL PROPERTY

LOCATION / DESCRIPTION
4540 LINCOLN DRIVE, Gasport, NY 14067, Absolut Center at Gasport

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COVERAGE INFORMATION

PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ 104,189,254 DED: 5,000

	YES	NO	N/A				
☒ BUSINESS INCOME ☐ RENTAL VALUE	X			If YES, LIMIT:	15,863,032	Actual Loss Sustained; # of months:	
BLANKET COVERAGE	X			If YES, indicate value(s) reported on property identified above: $	6,281,371		
TERRORISM COVERAGE	X			Attach Disclosure Notice / DEC			
IS THERE A TERRORISM-SPECIFIC EXCLUSION?			X				
IS DOMESTIC TERRORISM EXCLUDED?			X				
LIMITED FUNGUS COVERAGE			X	If YES, LIMIT:		DED:	
FUNGUS EXCLUSION (If "YES", specify organization's form used)			X				
REPLACEMENT COST	X						
AGREED VALUE	X						
COINSURANCE		X		If YES, %			
EQUIPMENT BREAKDOWN (If Applicable)	X			If YES, LIMIT:	5,943,561	DED:	5,000
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg	X			If YES, LIMIT:	5,943,561	DED:	5,000
- Demolition Costs	X			If YES, LIMIT:	1,000,000	DED:	5,000
- Incr. Cost of Construction	X			If YES, LIMIT:	1,000,000	DED:	5,000
EARTH MOVEMENT (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
FLOOD (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
WIND / HAIL INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
NAMED STORM INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS							

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

☐ CONTRACT OF SALE ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE
☐ MORTGAGEE

NAME AND ADDRESS
Absolut Center for Nursing and Rehabilitation at Gasport, LLC
Absolut at Gasport;
4540 Lincoln Drive
Gasport, NY 14067

LENDER SERVICING AGENT NAME AND ADDRESS

AUTHORIZED REPRESENTATIVE

ACORD 28 (2016/03)

NROCKOVE

ACORD

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY) 6/11/2019

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PRODUCER NAME, CONTACT PERSON AND ADDRESS Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204 Contact name:	PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): E-MAIL ADDRESS: CODE: SUB CODE: AGENCY CUSTOMER ID #: ABSOFAC-01
COMPANY NAME AND ADDRESS Great American Insurance Comp IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	NAIC NO: POLICY TYPE Property
NAMED INSURED AND ADDRESS Absolut Center for Nursing and Rehabilitaion at Orchard Park LLC Absolut at Orchard Brooke, LLC; 6060 Armor Road Orchard Park, NY 14127	LOAN NUMBER POLICY NUMBER: MAC457352310 EFFECTIVE DATE: 6/7/2019 EXPIRATION DATE: 8/9/2020 ☐ CONTINUED UNTIL TERMINATED IF CHECKED
ADDITIONAL NAMED INSURED(S)	THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION (ACORD 101 may be attached if more space is required) ☒ BUILDING OR ☒ BUSINESS PERSONAL PROPERTY

LOCATION / DESCRIPTION
6060 ARMOR ROAD, Orchard Park, NY 14127, Absolut Center at Orchard Park

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COVERAGE INFORMATION

PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ 104,189,254 DED: 5,000

	YES	NO	N/A				
☒ BUSINESS INCOME ☐ RENTAL VALUE	X			If YES, LIMIT:	15,863,032	Actual Loss Sustained; # of months:	
BLANKET COVERAGE	X			If YES, indicate value(s) reported on property identified above: $			28,585,318
TERRORISM COVERAGE	X			Attach Disclosure Notice / DEC			
IS THERE A TERRORISM-SPECIFIC EXCLUSION?			X				
IS DOMESTIC TERRORISM EXCLUDED?			X				
LIMITED FUNGUS COVERAGE			X	If YES, LIMIT:		DED:	
FUNGUS EXCLUSION (If "YES", specify organization's form used)			X				
REPLACEMENT COST	X						
AGREED VALUE	X						
COINSURANCE		X		If YES, %			
EQUIPMENT BREAKDOWN (If Applicable)	X			If YES, LIMIT:	20,430,904	DED:	5,000
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg	X			If YES, LIMIT:	20,430,904	DED:	5,000
- Demolition Costs	X			If YES, LIMIT:	1,000,000	DED:	5,000
- Incr. Cost of Construction	X			If YES, LIMIT:	1,000,000	DED:	5,000
EARTH MOVEMENT (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
FLOOD (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
WIND / HAIL INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
NAMED STORM INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS							

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

☐ CONTRACT OF SALE ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE
☐ MORTGAGEE

NAME AND ADDRESS
Absolut Center for Nursing and Rehabilitaion at Orchard Park LLC
Absolut at Orchard Brooke, LLC
6060 Armor Road
Orchard Park, NY 14127

LENDER SERVICING AGENT NAME AND ADDRESS

AUTHORIZED REPRESENTATIVE

NROCKOVE

ACORD

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY) 6/11/2019

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PRODUCER NAME, CONTACT PERSON AND ADDRESS Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204 Contact name:	PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): E-MAIL ADDRESS: CODE: SUB CODE: AGENCY CUSTOMER ID #: ABSOFAC-01
COMPANY NAME AND ADDRESS Great American Insurance Comp IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	NAIC NO: POLICY TYPE Property
NAMED INSURED AND ADDRESS Absolut Center for Nursing and Rehabilitation at Three Rivers LLC 101 Creekside Drive Painted Post, NY 14870	LOAN NUMBER POLICY NUMBER: MAC457352310 EFFECTIVE DATE: 6/7/2019 EXPIRATION DATE: 8/9/2020 ☐ CONTINUED UNTIL TERMINATED IF CHECKED
ADDITIONAL NAMED INSURED(S)	THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION (ACORD 101 may be attached if more space is required) ☒ BUILDING OR ☒ BUSINESS PERSONAL PROPERTY

LOCATION / DESCRIPTION
101 CREEKSIDE DRIVE, Painted Post, NY 14870, Absolut Center at Three Rivers

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COVERAGE INFORMATION PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ 104,189,254 DED: 5,000

	YES	NO	N/A				
☒ BUSINESS INCOME ☐ RENTAL VALUE	X			If YES, LIMIT:	15,863,032	Actual Loss Sustained; # of months:	
BLANKET COVERAGE	X			If YES, indicate value(s) reported on property identified above: $			15,721,812
TERRORISM COVERAGE	X			Attach Disclosure Notice / DEC			
IS THERE A TERRORISM-SPECIFIC EXCLUSION?			X				
IS DOMESTIC TERRORISM EXCLUDED?			X				
LIMITED FUNGUS COVERAGE			X	If YES, LIMIT:		DED:	
FUNGUS EXCLUSION (If "YES", specify organization's form used)			X				
REPLACEMENT COST	X						
AGREED VALUE	X						
COINSURANCE		X		If YES, %			
EQUIPMENT BREAKDOWN (If Applicable)	X			If YES, LIMIT:		DED:	
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg	X			If YES, LIMIT:	15,283,817	DED:	5,000
- Demolition Costs	X			If YES, LIMIT:	1,000,000	DED:	5,000
- Incr. Cost of Construction	X			If YES, LIMIT:	1,000,000	DED:	5,000
EARTH MOVEMENT (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
FLOOD (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
WIND / HAIL INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
NAMED STORM INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS							

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

☐ CONTRACT OF SALE ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE ☐ MORTGAGEE NAME AND ADDRESS Absolut Center for Nursing and Rehabilitation at Three Rivers LLC 101 Creekside Drive Painted Post, NY 14870	LENDER SERVICING AGENT NAME AND ADDRESS AUTHORIZED REPRESENTATIVE Michael Schummer

ACORD 28 (2016/03)

NROCKOVE

ACORD

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY) 6/11/2019

THIS EVIDENCE OF COMMERCIAL PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

PRODUCER NAME, CONTACT PERSON AND ADDRESS	PHONE (A/C, No, Ext):	COMPANY NAME AND ADDRESS	NAIC NO:
Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204 Contact name:	(718) 333-1155	Great American Insurance Comp	
FAX (A/C, No):	E-MAIL ADDRESS:	IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	
CODE:	SUB CODE:	POLICY TYPE: Property	
AGENCY CUSTOMER ID #: ABSOFAC-01			
NAMED INSURED AND ADDRESS: Absolut Center for Nursing And Rehabilitation At Westfield, LLC 26 Cass Street Westfield, NY 14787		LOAN NUMBER	POLICY NUMBER: MAC457352310
		EFFECTIVE DATE: 6/7/2019	EXPIRATION DATE: 8/9/2020 — ☐ CONTINUED UNTIL TERMINATED IF CHECKED
ADDITIONAL NAMED INSURED(S)		THIS REPLACES PRIOR EVIDENCE DATED:	

PROPERTY INFORMATION (ACORD 101 may be attached if more space is required) ☒ BUILDING OR ☒ BUSINESS PERSONAL PROPERTY

LOCATION / DESCRIPTION
26 CASS STREET, Westfield, NY 14787, Absolut Center at Westfield

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ 104,189,254 DED: 5,000

	YES	NO	N/A				
☒ BUSINESS INCOME ☐ RENTAL VALUE	X			If YES, LIMIT:	1,916,165	Actual Loss Sustained; # of months:	
BLANKET COVERAGE	X			If YES, indicate value(s) reported on property identified above: $			8,769,243
TERRORISM COVERAGE	X			Attach Disclosure Notice / DEC			
IS THERE A TERRORISM-SPECIFIC EXCLUSION?			X				
IS DOMESTIC TERRORISM EXCLUDED?			X				
LIMITED FUNGUS COVERAGE			X	If YES, LIMIT:		DED:	
FUNGUS EXCLUSION (If "YES", specify organization's form used)			X				
REPLACEMENT COST	X						
AGREED VALUE	X						
COINSURANCE		X		If YES, %			
EQUIPMENT BREAKDOWN (If Applicable)	X			If YES, LIMIT:	100,000,000	DED:	
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg	X			If YES, LIMIT:	8,331,098	DED:	5,000
- Demolition Costs	X			If YES, LIMIT:	1,000,000	DED:	5,000
- Incr. Cost of Construction	X			If YES, LIMIT:	1,000,000	DED:	5,000
EARTH MOVEMENT (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
FLOOD (If Applicable)	X			If YES, LIMIT:	1,000,000	DED:	25,000
WIND / HAIL INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
NAMED STORM INCL ☒ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT:		DED:	
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS							

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

☐ CONTRACT OF SALE ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE ☐ MORTGAGEE

NAME AND ADDRESS

Absolut Center for Nursing And Rehabilitation At Westfield, LLC
26 Cass Street
Westfield, NY 14787

LENDER SERVICING AGENT NAME AND ADDRESS

AUTHORIZED REPRESENTATIVE

ACORD 28 (2016/03)

ABSOFAC-01 NROCKOVE

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/12/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	PHONE (A/C, No, Ext): (718) 333-1155	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Lloyds Of London	
INSURED	INSURER B :	
Absolut Facilities Management 300 Gleed Avenue East Aurora, NY 14052-2983	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	X CLAIMS-MADE ☐ OCCUR			TBD	9/8/2019	9/8/2020	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	X Retro Date 6/7/07						MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ Included
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$ Included
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Prof. Liability			TBD	9/8/2019	9/8/2020	Limit	1,000,000
A	Retro Date 6/7/07			TBD	9/8/2019	9/8/2020	Aggregate	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Coverage is subject to court approval of continuous insurance payments as per payment schedule, including the down payment and installments.

Facilities Included:
Absolut Center for Nursing And Rehabilitation At Westfield, LLC
26 Cass Street
Westfield, NY 14787

SEE ATTACHED ACORD 101

CERTIFICATE HOLDER

Absolut Facilities Management
300 Gleed Avenue
East Aurora, NY 14052

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schwimmer

AGENCY CUSTOMER ID: ABSOFAC-01 NROCKOVE

LOC #: 1

ACORD

ADDITIONAL REMARKS SCHEDULE

AGENCY		NAMED INSURED
Grandview Brokerage Corp		Absolut Facilities Management 300 Gleed Avenue East Aurora, NY 14052-2983
POLICY NUMBER		
SEE PAGE 1		
CARRIER	NAIC CODE	EFFECTIVE DATE: SEE PAGE 1
SEE PAGE 1	SEE P 1	

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: ACORD 25 FORM TITLE: Certificate of Liability Insurance

Description of Operations/Locations/Vehicles:
Absolut Center for Nursing and Rehabilitation at Three Rivers LLC
101 Creekside Drive
Painted Post, NY 14870

Absolut Center for Nursing and Rehabilitaion at Orchard Park LLC
Absolut at Orchard Brooke, LLC
6060 Armor Road
Orchard Park, NY 14127

Absolut Center for Nursing and Rehabilitation at Gasport, LLC
4540 Lincoln Road
Gasport, NY 14067

Absolut Center for Nursing and Rehabilitation at Aurora Park, LLC
292 Main Street
East Aurora, NY 14052

Absolut Center for Nursing and Rehabilitation at Allegany, LLC
2178 North Fifth Street
Allegany, NY 14706

WESTFIELD TO BE ADDED

ABSOFAC-01 PGLICKSMAN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/3/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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PRODUCER	CONTACT NAME:	
Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	PHONE (A/C, No, Ext): (718) 333-1155	FAX (A/C, No): (917) 534-6087
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : American Guarantee and Liability Insurance Company	26247
INSURED	INSURER B :	
Absolut Facilities Management, LLC 300 Gleed Ave East Aurora, NY 14052-2983	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N ☐	N / A		WC011627602	5/1/2019	5/1/2020	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Facilities Management, LLC
300 Gleed Ave
East Aurora, NY 14052

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schwimmer

ABSOFAC-01 PGLICKSMAN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/3/2019

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PRODUCER Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	CONTACT NAME: PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): (917) 534-6087 E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : American Guarantee and Liability Insurance Company	26247
INSURED Absolut Center for Nursing and Rehabilitation at Allegany, LLC 2178 N Fifth St Allegany, NY 14706	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			WC011627602	5/1/2019	5/1/2020	☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ☐ N / A						E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Allegany, LLC
2178 N Fifth St
Allegany, NY 14706

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schwimmer

ACORD 25 (2016/03)

ABSOFAC-01 PGLICKSMAN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/3/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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PRODUCER	CONTACT NAME:	
Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	PHONE (A/C, No, Ext): (718) 333-1155	FAX (A/C, No): (917) 534-6087
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : American Guarantee and Liability Insurance Company	26247
INSURED Absolut Center for Nursing and Rehabilitation at Aurora Park, LLC 292 Main St East Aurora, NY 14052	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			WC011627602	5/1/2019	5/1/2020	☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ☐	N / A					E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Aurora Park, LLC
292 Main St
East Aurora, NY 14052

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schwarz

ABSOFAC-01 PGLICKSMAN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/3/2019

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PRODUCER Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	CONTACT NAME: PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): (917) 534-6087 E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : American Guarantee and Liability Insurance Company	26247
INSURED Absolut Center for Nursing And Rehabilitation at Gasport, LLC 4540 Lincoln Dr Gasport, NY 14067	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A		WC011627602	5/1/2019	5/1/2020	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing And Rehabilitation at Gasport, LLC
4540 Lincoln Dr
Gasport, NY 14067

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

ABSOFAC-01 PGLICKSMAN

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/3/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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PRODUCER Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	CONTACT NAME: PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): (917) 534-6087 E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : American Guarantee and Liability Insurance Company	26247
INSURED Absolut at Orchard Brooke, LLC 6060 Armor Duells Rd Orchard Park, NY 14127	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N / A		WC011627602	5/1/2019	5/1/2020	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut at Orchard Brooke, LLC
6060 Armor Duells Rd
Orchard Park, NY 14127

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Lehmann

ABSOFAC-01 PGLICKSMAN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/3/2019

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PRODUCER Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	CONTACT NAME: PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): (917) 534-6087 E-MAIL ADDRESS:
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : American Guarantee and Liability Insurance Company 26247
INSURED Absolut Center For Nursing and Rehabilitation at Orchard Park, LLC 6060 Armor Rd Orchard Park, NY 14127	INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			WC011627602	5/1/2019	5/1/2020	☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ☐ N/A						E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center For Nursing and Rehabilitation at Orchard Park, LLC
6060 Armor Rd
Orchard Park, NY 14127

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schwimmer

ACORD 25 (2016/03)

ABSOFAC-01 PGLICKSMAN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/3/2019

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PRODUCER Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	CONTACT NAME: PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): (917) 534-6087 E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : American Guarantee and Liability Insurance Company	26247
INSURED Absolut Center for Nursing and Rehabilitation at Three Rivers, LLC 101 Creekside Dr Painted Post, NY 14870	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A		WC011627602	5/1/2019	5/1/2020	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Three Rivers, LLC
101 Creekside Dr
Painted Post, NY 14870

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schwimmer

ACORD 25 (2016/03)

ABSOFAC-01 PGLICKSMAN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/3/2019

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PRODUCER Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	CONTACT NAME: PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): (917) 534-6087 E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : American Guarantee and Liability Insurance Company	26247
INSURED Absolut Center for Nursing and Rehabilitation at Westfield, LLC 26 Cass St Westfield, NY 14787	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N / A		WC011627602	5/1/2019	5/1/2020	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Westfield, LLC
26 Cass St
Westfield, NY 14787

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schwarz

ACORD 25 (2016/03)

STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

DB-820-829 09-17

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

☑ Initial ☐ Cancellation ☐ Reinstatement ☐ Supersedes **Transaction Effective Date:** 10/1/2016

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
Wesco Insurance Company 800 Plaza Two, 8th Floor, Jersey City, NJ 07311-1104	B904698	(800) 535-2711

4. CONTACT NAME	5. TITLE	6. DATE
Lydia De La Rosa-Pena	Associate VP	6/13/2019

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		208467875

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
Absolut Center For Nursing and Rehabilitation at Allegany LLC	10 - LLC
11. EMPLOYER STREET ADDRESS	**14. NUMBER (#) OF EMPLOYEES**
2178 N. Fifth Street	49
12. EMPLOYER CITY, STATE and ZIP CODE	**15. EMPLOYER PHONE #**
Allegany NY 14706	

C. POLICY * If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete item 18.

16. POLICY NUMBER	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER *
WDL10269714-013	10/1/2016	AH990118NY

19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT
	$1811.17

D. REASONS FOR CANCELLATION

☐ Non-Payment of Premium ☐ Other: _____

☐ Not Subject/No Eligible Employees Date: _____

☐ Out of Business Date: _____

☐ Seasonal Date: _____

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER: _____

E. Complete if SUPERSEDES box is checked at top of form

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	
22. EMPLOYER'S STREET ADDRESS	
23. CITY, STATE and ZIP CODE	
24. EMPLOYER FEIN	**25. POLICY EFFECTIVE DATE**
26. POLICY NUMBER	

F. POLICYHOLDER if different from Employer

27. POLICYHOLDER NAME
28. POLICYHOLDER ADDRESS
29. CITY, STATE and ZIP CODE
30. POLICYHOLDER FEIN

G. The policy covers Employer's employees as follows:

a. The policy provides coverage for:

☑ Both disability and paid family leave benefits

☐ Disability benefits only

☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:

☑ All employees

☐ Only the class or classes of employees listed here: _____

2. The employee contributions required and benefits insured are:

☑ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.

☐ As described in attached supplement, Form DB-820.1

☐ As described in Employer's Application for Acceptance of a Plan, Form DB-800, filed with and accepted by the Chair.

☐ As described in Certificate of Insurance, Form DB-820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ or amended Form DB-820.3 filed thereafter.

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204), OR benefits under a plan accepted by the Chair.

LEGAL STATUS - INSURED LEGAL STATUS

1	INDIVIDUAL	10	LIMITED LIABILITY COMPANY (LLC)
2	PARTNERSHIP	11	TRUST OR ESTATE
3	CORPORATION	12	EXECUTOR OR TRUSTEE
4	ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION		
5	LIMITED PARTNER	13	LIMITED LIABILITY PARTNERSHIP (LLP)
6	JOINT VENTURE	99	OTHER

STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

DB-820-829 09-17

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

☑ Initial ☐ Cancellation ☐ Reinstatement ☐ Supersedes **Transaction Effective Date:** 10/1/2016

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
Wesco Insurance Company 800 Plaza Two, 8th Floor, Jersey City, NJ 07311-1104	B904698	(800) 535-2711

4. CONTACT NAME	5. TITLE	6. DATE
Lydia De La Rosa-Pena	Associate VP	6/13/2019

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		208468266

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
Absolut Center for Nursing & Rehabilitation at Aurora Park LLC	10 - LLC
11. EMPLOYER STREET ADDRESS	**14. NUMBER (#) OF EMPLOYEES**
292 Main St	48
12. EMPLOYER CITY, STATE and ZIP CODE	**15. EMPLOYER PHONE #**
East Aurora NY 14052	

C. POLICY * If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete item 18.

16. POLICY NUMBER	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER *
WDL10269714-015	10/1/2016	AH990118NY

19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT
	$1891.60

D. REASONS FOR CANCELLATION

☐ Non-Payment of Premium ☐ Other: _____

☐ Not Subject/No Eligible Employees Date: _____

☐ Out of Business Date: _____

☐ Seasonal Date: _____

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER: _____

E. Complete if SUPERSEDES box is checked at top of form

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	
22. EMPLOYER'S STREET ADDRESS	
23. CITY, STATE and ZIP CODE	
24. EMPLOYER FEIN	**25. POLICY EFFECTIVE DATE**
26. POLICY NUMBER	

F. POLICYHOLDER if different from Employer

27. POLICYHOLDER NAME
28. POLICYHOLDER ADDRESS
29. CITY, STATE and ZIP CODE
30. POLICYHOLDER FEIN

G. 1. The policy covers Employer's employees as follows:

a. The policy provides coverage for:

☑ Both disability and paid family leave benefits

☐ Disability benefits only

☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:

☑ All employees

☐ Only the class or classes of employees listed here:

_____

_____

2. The employee contributions required and benefits insured are:

☑ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.

☐ As described in attached supplement, Form DB-820.1

☐ As described in Employer's Application for Acceptance of a Plan, Form DB-800, filed with and accepted by the Chair.

☐ As described in Certificate of Insurance, Form DB-820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ or amended Form DB-820.3 filed thereafter.

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204), OR benefits under a plan accepted by the Chair.

LEGAL STATUS - INSURED LEGAL STATUS

1	INDIVIDUAL	10	LIMITED LIABILITY COMPANY (LLC)
2	PARTNERSHIP	11	TRUST OR ESTATE
3	CORPORATION	12	EXECUTOR OR TRUSTEE
4	ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION		
5	LIMITED PARTNER	13	LIMITED LIABILITY PARTNERSHIP (LLP)
6	JOINT VENTURE	99	OTHER

STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

DB-820-829 09-17

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

☑ Initial ☐ Cancellation ☐ Reinstatement ☐ Supersedes **Transaction Effective Date:** 10/1/2016

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
Wesco Insurance Company 800 Plaza Two, 8th Floor, Jersey City, NJ 07311-1104	B904698	(800) 535-2711

4. CONTACT NAME	5. TITLE	6. DATE
Lydia De La Rosa-Pena	Associate VP	6/13/2019

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		208468080

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
Absolut Center For Nursing and Rehabilitation at Gasport LLC	10 - LLC
11. EMPLOYER STREET ADDRESS	**14. NUMBER (#) OF EMPLOYEES**
4540 Lincoln Drive	90
12. EMPLOYER CITY, STATE and ZIP CODE	**15. EMPLOYER PHONE #**
Gasport NY 14067	

C. POLICY * If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete item 18.

16. POLICY NUMBER	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER *
WDL10269714-002	10/1/2016	AH990118NY

19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT
	$3383.43

D. REASONS FOR CANCELLATION

☐ Non-Payment of Premium ☐ Other: _____

☐ Not Subject/No Eligible Employees Date: _____

☐ Out of Business Date: _____

☐ Seasonal Date: _____

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER: _____

E. Complete if SUPERSEDES box is checked at top of form

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	
22. EMPLOYER'S STREET ADDRESS	
23. CITY, STATE and ZIP CODE	
24. EMPLOYER FEIN	**25. POLICY EFFECTIVE DATE**
26. POLICY NUMBER	

F. POLICYHOLDER if different from Employer

27. POLICYHOLDER NAME
28. POLICYHOLDER ADDRESS
29. CITY, STATE and ZIP CODE
30. POLICYHOLDER FEIN

G. 1. The policy covers Employer's employees as follows:

a. The policy provides coverage for:

☑ Both disability and paid family leave benefits

☐ Disability benefits only

☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:

☑ All employees

☐ Only the class or classes of employees listed here: _____

2. The employee contributions required and benefits insured are:

☑ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.

☐ As described in attached supplement, Form DB-820.1

☐ As described in Employer's Application for Acceptance of a Plan, Form DB-800, filed with and accepted by the Chair.

☐ As described in Certificate of Insurance, Form DB-820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ or amended Form DB-820.3 filed thereafter.

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204), OR benefits under a plan accepted by the Chair.

LEGAL STATUS - INSURED LEGAL STATUS

1	INDIVIDUAL	10	LIMITED LIABILITY COMPANY (LLC)
2	PARTNERSHIP	11	TRUST OR ESTATE
3	CORPORATION	12	EXECUTOR OR TRUSTEE
4	ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION		
5	LIMITED PARTNER	13	LIMITED LIABILITY PARTNERSHIP (LLP)
6	JOINT VENTURE	99	OTHER

STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

DB-820-829 09-17

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

☑ Initial ☐ Cancellation ☐ Reinstatement ☐ Supersedes **Transaction Effective Date:** 10/1/2016

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
Wesco Insurance Company 800 Plaza Two, 8th Floor, Jersey City, NJ 07311-1104	B904698	(800) 535-2711

4. CONTACT NAME	5. TITLE	6. DATE
Lydia De La Rosa-Pena	Associate VP	6/13/2019

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		208471641

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
Absolut at Orchard Brooke LLC	10 - LLC
11. EMPLOYER STREET ADDRESS	**14. NUMBER (#) OF EMPLOYEES**
6060 Armor Road	18
12. EMPLOYER CITY, STATE and ZIP CODE	**15. EMPLOYER PHONE #**
Orchard Park NY 14127	

C. POLICY * If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete item 18.

16. POLICY NUMBER	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER *
WDL10269714-003	10/1/2016	AH990118NY

19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT
	$678.35

D. REASONS FOR CANCELLATION

☐ Non-Payment of Premium ☐ Other: _____

☐ Not Subject/No Eligible Employees Date: _____

☐ Out of Business Date: _____

☐ Seasonal Date: _____

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER: _____

E. Complete if SUPERSEDES box is checked at top of form

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	
22. EMPLOYER'S STREET ADDRESS	
23. CITY, STATE and ZIP CODE	
24. EMPLOYER FEIN	**25. POLICY EFFECTIVE DATE**
26. POLICY NUMBER	

F. POLICYHOLDER if different from Employer

27. POLICYHOLDER NAME
28. POLICYHOLDER ADDRESS
29. CITY, STATE and ZIP CODE
30. POLICYHOLDER FEIN

G. 1. The policy covers Employer's employees as follows:

a. The policy provides coverage for:

☑ Both disability and paid family leave benefits

☐ Disability benefits only

☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:

☑ All employees

☐ Only the class or classes of employees listed here:

_____

_____

2. The employee contributions required and benefits insured are:

☑ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.

☐ As described in attached supplement, Form DB-820.1

☐ As described in Employer's Application for Acceptance of a Plan, Form DB-800, filed with and accepted by the Chair.

☐ As described in Certificate of Insurance, Form DB-820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ or amended Form DB-820.3 filed thereafter.

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204), OR benefits under a plan accepted by the Chair.

LEGAL STATUS - INSURED LEGAL STATUS

1	INDIVIDUAL	10	LIMITED LIABILITY COMPANY (LLC)
2	PARTNERSHIP	11	TRUST OR ESTATE
3	CORPORATION	12	EXECUTOR OR TRUSTEE
4	ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION		
5	LIMITED PARTNER	13	LIMITED LIABILITY PARTNERSHIP (LLP)
6	JOINT VENTURE	99	OTHER

STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

DB-820-829 09-17

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

☑ Initial ☐ Cancellation ☐ Reinstatement ☐ Supersedes **Transaction Effective Date:** 10/1/2016

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
Wesco Insurance Company 800 Plaza Two, 8th Floor, Jersey City, NJ 07311-1104	B904698	(800) 535-2711

4. CONTACT NAME	5. TITLE	6. DATE
Lydia De La Rosa-Pena	Associate VP	6/13/2019

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		208468300

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
Absolut Center For Nursing and Rehabilitation at Orchard Park LLC	10 - LLC
11. EMPLOYER STREET ADDRESS	**14. NUMBER (#) OF EMPLOYEES**
6060 Armor Road	221
12. EMPLOYER CITY, STATE and ZIP CODE	**15. EMPLOYER PHONE #**
Orchard Park NY 14127	

C. POLICY * If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete item 18.

16. POLICY NUMBER	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER *
WDL10269714-007	10/1/2016	AH990118NY

19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT
	$8215.59

D. REASONS FOR CANCELLATION

☐ Non-Payment of Premium ☐ Other: _____

☐ Not Subject/No Eligible Employees Date: _____

☐ Out of Business Date: _____

☐ Seasonal Date: _____

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER: _____

E. Complete if SUPERSEDES box is checked at top of form.

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)		
22. EMPLOYER'S STREET ADDRESS		
23. CITY, STATE and ZIP CODE		
24. EMPLOYER FEIN	**25. POLICY EFFECTIVE DATE**	
26. POLICY NUMBER		

F. POLICYHOLDER If different from Employer

27. POLICYHOLDER NAME
28. POLICYHOLDER ADDRESS
29. CITY, STATE and ZIP CODE
30. POLICYHOLDER FEIN

G. 1. The policy covers Employer's employees as follows:

a. The policy provides coverage for:

☑ Both disability and paid family leave benefits

☐ Disability benefits only

☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:

☑ All employees

☐ Only the class or classes of employees listed here:

_____

_____

2. The employee contributions required and benefits insured are:

☑ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.

☐ As described in attached supplement, Form DB-820.1

☐ As described in Employer's Application for Acceptance of a Plan, Form DB-800, filed with and accepted by the Chair.

☐ As described in Certificate of Insurance, Form DB-820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ or amended Form DB-820.3 filed thereafter.

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204), OR benefits under a plan accepted by the Chair.

LEGAL STATUS - INSURED LEGAL STATUS

1	INDIVIDUAL	10	LIMITED LIABILITY COMPANY (LLC)
2	PARTNERSHIP	11	TRUST OR ESTATE
3	CORPORATION	12	EXECUTOR OR TRUSTEE
4	ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION		
5	LIMITED PARTNER	13	LIMITED LIABILITY PARTNERSHIP (LLP)
6	JOINT VENTURE	99	OTHER

STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

DB-820-829 09-17

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

☑ Initial ☐ Cancellation ☐ Reinstatement ☐ Supersedes **Transaction Effective Date:** 10/1/2016

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
Wesco Insurance Company 800 Plaza Two, 8th Floor, Jersey City, NJ 07311-1104	B904698	(800) 535-2711

4. CONTACT NAME	5. TITLE	6. DATE
Lydia De La Rosa-Pena	Associate VP	6/13/2019

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		208468133

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
Absolut Center For Nursing and Rehabilitation at Three Rivers LLC	10 - LLC
11. EMPLOYER STREET ADDRESS	**14. NUMBER (#) OF EMPLOYEES**
101 Creekside Drive	120
12. EMPLOYER CITY, STATE and ZIP CODE	**15. EMPLOYER PHONE #**
Painted Post NY 14870	

C. POLICY * If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete item 18.

16. POLICY NUMBER	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER *
WDL10269714-008	10/1/2016	AH990118NY

19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT
	$4555.69

D. REASONS FOR CANCELLATION

☐ Non-Payment of Premium ☐ Other: _____

☐ Not Subject/No Eligible Employees Date: _____

☐ Out of Business Date: _____

☐ Seasonal Date: _____

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER: _____

E. Complete if SUPERSEDES box is checked at top of form

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	
22. EMPLOYER'S STREET ADDRESS	
23. CITY, STATE and ZIP CODE	
24. EMPLOYER FEIN	**25. POLICY EFFECTIVE DATE**
26. POLICY NUMBER	

F. POLICYHOLDER if different from Employer

27. POLICYHOLDER NAME
28. POLICYHOLDER ADDRESS
29. CITY, STATE and ZIP CODE
30. POLICYHOLDER FEIN

G. 1. The policy covers Employer's employees as follows:

a. The policy provides coverage for:

☑ Both disability and paid family leave benefits

☐ Disability benefits only

☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:

☑ All employees

☐ Only the class or classes of employees listed here: _____

2. The employee contributions required and benefits insured are:

☑ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.

☐ As described in attached supplement, Form DB-820.1

☐ As described in Employer's Application for Acceptance of a Plan, Form DB-800, filed with and accepted by the Chair.

☐ As described in Certificate of Insurance, Form DB-820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ or amended Form DB-820.3 filed thereafter.

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204), OR benefits under a plan accepted by the Chair.

LEGAL STATUS - INSURED LEGAL STATUS

1	INDIVIDUAL
2	PARTNERSHIP
3	CORPORATION
4	ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION
5	LIMITED PARTNER
6	JOINT VENTURE
10	LIMITED LIABILITY COMPANY (LLC)
11	TRUST OR ESTATE
12	EXECUTOR OR TRUSTEE
13	LIMITED LIABILITY PARTNERSHIP (LLP)
99	OTHER

STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

DB-820-829 09-17

☑ Initial ☐ Cancellation ☐ Reinstatement ☐ Supersedes **Transaction Effective Date:** 10/1/2016

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
Wesco Insurance Company 800 Plaza Two, 8th Floor, Jersey City, NJ 07311-1104	B904698	(800) 535-2711

4. CONTACT NAME	5. TITLE	6. DATE
Lydia De La Rosa-Pena	Associate VP	6/13/2019

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		208467924

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
Absolut Center for Nursing and Rehabilitation at Westfield LLC	10 - LLC
11. EMPLOYER STREET ADDRESS	**14. NUMBER (#) OF EMPLOYEES**
26 Cass Street	140
12. EMPLOYER CITY, STATE and ZIP CODE	**15. EMPLOYER PHONE #**
Westfield NY 14787	

C. POLICY * If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete item 18.

16. POLICY NUMBER	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER *
WDL10269714-009	10/1/2016	AH990118NY

19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT
	$4833.02

D. REASONS FOR CANCELLATION

☐ Non-Payment of Premium ☐ Other: _____

☐ Not Subject/No Eligible Employees Date: _____

☐ Out of Business Date: _____

☐ Seasonal Date: _____

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER: _____

E. Complete if SUPERSEDES box is checked at top of form

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	
22. EMPLOYER'S STREET ADDRESS	
23. CITY, STATE and ZIP CODE	
24. EMPLOYER FEIN	**25. POLICY EFFECTIVE DATE**
26. POLICY NUMBER	

F. POLICYHOLDER If different from Employer

27. POLICYHOLDER NAME
28. POLICYHOLDER ADDRESS
29. CITY, STATE and ZIP CODE
30. POLICYHOLDER FEIN

G. 1. The policy covers Employer's employees as follows:

a. The policy provides coverage for:

☑ Both disability and paid family leave benefits

☐ Disability benefits only

☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:

☑ All employees

☐ Only the class or classes of employees listed here: _____

2. The employee contributions required and benefits insured are:

☑ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.

☐ As described in attached supplement, Form DB-820.1

☐ As described in Employer's Application for Acceptance of a Plan, Form DB-800, filed with and accepted by the Chair.

☐ As described in Certificate of Insurance, Form DB-820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ or amended Form DB-820.3 filed thereafter.

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204), OR benefits under a plan accepted by the Chair.

LEGAL STATUS - INSURED LEGAL STATUS

1	INDIVIDUAL
2	PARTNERSHIP
3	CORPORATION
4	ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION
5	LIMITED PARTNER
6	JOINT VENTURE
10	LIMITED LIABILITY COMPANY (LLC)
11	TRUST OR ESTATE
12	EXECUTOR OR TRUSTEE
13	LIMITED LIABILITY PARTNERSHIP (LLP)
99	OTHER

WESCO INSURANCE COMPANY

Absolut Facilities Management LLC

STATE OF NEW YORK

WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For Employees

1. If you are unable to work because of an illness or injury, not work-related, you may be entitled to receive weekly benefits from your employer, his or her insurance carrier, or from the Special Fund for Disability Benefits.
2. To claim benefits you must file a claim form within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Complete claim form DB-450 (Notice and Proof of Claim for Disability Benefits)
   You may obtain the form from your employer, his or her insurance carrier, your health provider, any Unemployment Insurance Office, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board.
   IMPORTANT: Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the form showing your period of disability.
   - If you are employed, or have been unemployed for four weeks or less when your disability begins, send the completed form to your employer or the insurance carrier named below.
   - If you have been unemployed more than four weeks when your disability begins, send the completed form to the Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
4. You are entitled to be treated by any physician,chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.
5. If you are ill or injured during the time you are receiving Unemployment Insurance Benefits, file a claim for Disability Benefits as soon as you sustain the injury or illness, by following the instructions outlined above.
6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271S).
7. You may not take disability benefits at the same time as paid family leave benefits. The total amount of disability and paid family leave in a 52 week period cannot exceed 26 weeks.
8. Other information about disability benefits may be obtained by writing or calling the Workers' Compensation Board.

WESCO INSURANCE COMPANY
800 Plaza Two, 8th Floor
Jersey City, New Jersey 07311-1104
PHONE: (800) 535-2711

Policy #: WDL10269714-001 Effective From: 10/1/2016 To: 12/31/2020

☑ Statutory ☐ Under a Plan or Agreement

Class(es) of Employees Covered:

All Employees

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.
Employers must post DB-120 so that all classes of their employees know who will pay their benefits.

DB-120 (11-17)

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

WESCO INSURANCE COMPANY

Absolut Center For Nursing and Rehabilitation at Allegany LLC

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For Employees

1. If you are unable to work because of an illness or injury, not work-related, you may be entitled to receive weekly benefits from your employer, his or her insurance carrier, or from the Special Fund for Disability Benefits.
2. To claim benefits you must file a claim form within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Complete claim form DB-450 (Notice and Proof of Claim for Disability Benefits)
   You may obtain the form from your employer, his or her insurance carrier, your health provider, any Unemployment Insurance Office, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board.
   IMPORTANT: Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the form showing your period of disability.
   - If you are employed, or have been unemployed for four weeks or less when your disability begins, send the completed form to your employer or the insurance carrier named below.
   - If you have been unemployed more than four weeks when your disability begins, send the completed form to the Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
4. You are entitled to be treated by any physician,chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.
5. If you are ill or injured during the time you are receiving Unemployment Insurance Benefits, file a claim for Disability Benefits as soon as you sustain the injury or illness, by following the instructions outlined above.
6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271S).
7. You may not take disability benefits at the same time as paid family leave benefits. The total amount of disability and paid family leave in a 52 week period cannot exceed 26 weeks.
8. Other information about disability benefits may be obtained by writing or calling the Workers' Compensation Board.

WESCO INSURANCE COMPANY
800 Plaza Two, 8th Floor
Jersey City, New Jersey 07311-1104
PHONE: (800) 535-2711

Policy #: WDL10269714-013 Effective From: 10/1/2016 To: 12/31/2020

☑ Statutory ☐ Under a Plan or Agreement

Class(es) of Employees Covered:

All Employees

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.
Employers must post DB-120 so that all classes of their employees know who will pay their benefits.

WESCO INSURANCE COMPANY

Absolut Center for Nursing & Rehabilitation at Aurora Park LLC

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For Employees

1. If you are unable to work because of an illness or injury, not work-related, you may be entitled to receive weekly benefits from your employer, his or her insurance carrier, or from the Special Fund for Disability Benefits.
2. To claim benefits you must file a claim form within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Complete claim form DB-450 (Notice and Proof of Claim for Disability Benefits)
   You may obtain the form from your employer, his or her insurance carrier, your health provider, any Unemployment Insurance Office, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board.
   IMPORTANT: Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the form showing your period of disability.
   - If you are employed, or have been unemployed for four weeks or less when your disability begins, send the completed form to your employer or the insurance carrier named below.
   - If you have been unemployed more than four weeks when your disability begins, send the completed form to the Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
4. You are entitled to be treated by any physician,chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.
5. If you are ill or injured during the time you are receiving Unemployment Insurance Benefits, file a claim for Disability Benefits as soon as you sustain the injury or illness, by following the instructions outlined above.
6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271S).
7. You may not take disability benefits at the same time as paid family leave benefits. The total amount of disability and paid family leave in a 52 week period cannot exceed 26 weeks.
8. Other information about disability benefits may be obtained by writing or calling the Workers' Compensation Board.

WESCO INSURANCE COMPANY
800 Plaza Two, 8th Floor
Jersey City, New Jersey 07311-1104
PHONE: (800) 535-2711

Policy #: WDL10269714-015 Effective From: 10/1/2016 To: 12/31/2020

☑ Statutory ☐ Under a Plan or Agreement

Class(es) of Employees Covered:

All Employees

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.
Employers must post DB-120 so that all classes of their employees know who will pay their benefits.

DB-120 (11-17)

WESCO INSURANCE COMPANY

Absolut Center For Nursing and Rehabilitation at Gasport LLC

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For Employees

1. If you are unable to work because of an illness or injury, not work-related, you may be entitled to receive weekly benefits from your employer, his or her insurance carrier, or from the Special Fund for Disability Benefits.
2. To claim benefits you must file a claim form within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Complete claim form DB-450 (Notice and Proof of Claim for Disability Benefits)
   You may obtain the form from your employer, his or her insurance carrier, your health provider, any Unemployment Insurance Office, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board.
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   - If you are employed, or have been unemployed for four weeks or less when your disability begins, send the completed form to your employer or the insurance carrier named below.
   - If you have been unemployed more than four weeks when your disability begins, send the completed form to the Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
4. You are entitled to be treated by any physician,chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.
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6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271S).
7. You may not take disability benefits at the same time as paid family leave benefits. The total amount of disability and paid family leave in a 52 week period cannot exceed 26 weeks.
8. Other information about disability benefits may be obtained by writing or calling the Workers' Compensation Board.

WESCO INSURANCE COMPANY
800 Plaza Two, 8th Floor
Jersey City, New Jersey 07311-1104
PHONE: (800) 535-2711

Policy #: WDL10269714-002 Effective From: 10/1/2016 To: 12/31/2020

☑ Statutory ☐ Under a Plan or Agreement

Class(es) of Employees Covered:

All Employees

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.
Employers must post DB-120 so that all classes of their employees know who will pay their benefits.

DB-120 (11-17)

WESCO INSURANCE COMPANY

Absolut at Orchard Brooke LLC

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For Employees

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2. To claim benefits you must file a claim form within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Complete claim form DB-450 (Notice and Proof of Claim for Disability Benefits)
   You may obtain the form from your employer, his or her insurance carrier, your health provider, any Unemployment Insurance Office, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board.
   IMPORTANT: Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the form showing your period of disability.
   - If you are employed, or have been unemployed for four weeks or less when your disability begins, send the completed form to your employer or the insurance carrier named below.
   - If you have been unemployed more than four weeks when your disability begins, send the completed form to the Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
4. You are entitled to be treated by any physician,chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.
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7. You may not take disability benefits at the same time as paid family leave benefits. The total amount of disability and paid family leave in a 52 week period cannot exceed 26 weeks.
8. Other information about disability benefits may be obtained by writing or calling the Workers' Compensation Board.

WESCO INSURANCE COMPANY
800 Plaza Two, 8th Floor
Jersey City, New Jersey 07311-1104
PHONE: (800) 535-2711

Policy #: WDL10269714-003 Effective From: 10/1/2016 To: 12/31/2020

☑ Statutory ☐ Under a Plan or Agreement

Class(es) of Employees Covered:

All Employees

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.
Employers must post DB-120 so that all classes of their employees know who will pay their benefits.

DB-120 (11-17)

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

WESCO INSURANCE COMPANY

Absolut Center For Nursing and Rehabilitation at Orchard Park LLC

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For Employees

1. If you are unable to work because of an illness or injury, not work-related, you may be entitled to receive weekly benefits from your employer, his or her insurance carrier, or from the Special Fund for Disability Benefits.
2. To claim benefits you must file a claim form within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Complete claim form DB-450 (Notice and Proof of Claim for Disability Benefits)
   You may obtain the form from your employer, his or her insurance carrier, your health provider, any Unemployment Insurance Office, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board.
   IMPORTANT: Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the form showing your period of disability.
   - If you are employed, or have been unemployed for four weeks or less when your disability begins, send the completed form to your employer or the insurance carrier named below.
   - If you have been unemployed more than four weeks when your disability begins, send the completed form to the Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
4. You are entitled to be treated by any physician,chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.
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6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271S).
7. You may not take disability benefits at the same time as paid family leave benefits. The total amount of disability and paid family leave in a 52 week period cannot exceed 26 weeks.
8. Other information about disability benefits may be obtained by writing or calling the Workers' Compensation Board.

WESCO INSURANCE COMPANY
800 Plaza Two, 8th Floor
Jersey City, New Jersey 07311-1104
PHONE: (800) 535-2711

Policy #: WDL10269714-007 Effective From: 10/1/2016 To: 12/31/2020

☑ Statutory ☐ Under a Plan or Agreement

Class(es) of Employees Covered:

All Employees

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.
Employers must post DB-120 so that all classes of their employees know who will pay their benefits.

WESCO INSURANCE COMPANY

Absolut Center For Nursing and Rehabilitation at Three Rivers LLC

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For Employees

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2. To claim benefits you must file a claim form within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
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   You may obtain the form from your employer, his or her insurance carrier, your health provider, any Unemployment Insurance Office, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board.
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WESCO INSURANCE COMPANY
800 Plaza Two, 8th Floor
Jersey City, New Jersey 07311-1104
PHONE: (800) 535-2711

Policy #: WDL10269714-008 Effective From: 10/1/2016 To: 12/31/2020

☑ Statutory ☐ Under a Plan or Agreement

Class(es) of Employees Covered:

All Employees

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
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WESCO INSURANCE COMPANY

Absolut Center for Nursing and Rehabilitation at Westfield LLC

STATE OF NEW YORK

WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For Employees

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WESCO INSURANCE COMPANY
800 Plaza Two, 8th Floor
Jersey City, New Jersey 07311-1104
PHONE: (800) 535-2711

Policy #: WDL10269714-009 Effective From: 10/1/2016 To: 12/31/2020

☑ Statutory ☐ Under a Plan or Agreement

Class(es) of Employees Covered:

All Employees

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.
Employers must post DB-120 so that all classes of their employees know who will pay their benefits.

DB-120 (11-17)

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 09/20/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Debbie Kinkead	
TIS Insurance Services, Inc. 1900 Winston Road, Suite 100 P.O. Box 10328 Knoxville TN 37939-0328	PHONE (A/C, No, Ext): (865) 691-4847	FAX (A/C, No): (865) 694-4847
	E-MAIL ADDRESS: dkinkead@tisins.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
INSURED Absolut Facilities Management, LLC 300 Gleed Avenue East Aurora NY 14052	INSURER A : Federal Insurance Co/Chubb	20281
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** 19-20 Crime **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N/A (Mandatory in NH)						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Crime Coverage Employee Dishonesty			82234980	03/15/2019	03/15/2020	Limit Includes ERISA-401k	$500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Certificate Holder is listed as Additional Notified Party

CERTIFICATE HOLDER

United States Trustee United States Federal Building
201 Varick Street, Suite 1006
New York NY 10014-4811

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Edward B. Sin

Additional Named Insureds

Other Named Insureds	
02 Absolut Ctr for Nurs & Rehab at Aurora Park LLC	FEIN: 20-8468266
03 Absolut Ctr for Nurs & Rehab at Orchard Park LLC	FEIN: 20-8468300
04 Absolut Ctr for Nurs & Rehab at Three Rivers LLC	FEIN: 20-8468133
05 Absolut Ctr for Nurs & Rehab at Westfield LLC	FEIN: 20-8467924
06 Absolut Ctr for Nurs & Rehab at Allegany LLC	FEIN: 20-8467875
07 Absolut Ctr for Nurs & Rehab at Gasport LLC	FEIN: 20-8468080
08 Absolut at Orchard Brooke, LLC	FEIN: 20-8471641

Mattucci, Lisa

From: Hayli Dunn <hdunn@tisins.com>
Sent: Friday, September 20, 2019 11:39 AM
To: Mattucci, Lisa
Cc: Hoffman, Phil
Subject: RE: Absolut Crime and Surety Bonds
Attachments: Absolut Facilities COI.PDF

Please see attached Crime certificate. I have submitted the request to be processed on the bonds, and documentation will be forwarded when possible.

Thank you,

Hayli Dunn

Account Manager
HealthCare Services Division
TIS Insurance Services, Inc.
1900 N. Winston Road, Suite 100
Knoxville, TN 37919
Learn more at TISins.com

o: 865.470.3712 m: 423.465.1824
f: 865.824.3912

From: Mattucci, Lisa <LISAM@billitco.com>
Sent: Friday, September 20, 2019 8:11 AM
To: Hayli Dunn <hdunn@tisins.com>
Cc: Hoffman, Phil <phoffman@billitco.com>
Subject: RE: Absolut Crime and Surety Bonds

United States Trustee
United States Federal Building
201 Varick Street, Suite 1006
New York, NY 10014-4811

From: Hayli Dunn [mailto:hdunn@tisins.com]
Sent: Friday, September 20, 2019 7:57 AM
To: Mattucci, Lisa
Cc: Hoffman, Phil
Subject: RE: Absolut Crime and Surety Bonds

Do have an address for United States Trustee?

Thank you!

CONTINUATION CERTIFICATE

In consideration of the premium charged, The Ohio Casualty Insurance Company, as Surety,

hereby continues in force BOND NO. 4036475

in the amount of Twenty Five Thousand Dollars ($25,000.00),

on behalf of Absolut Center for Nursing & Rehabilitation at Allegany, LLC as Principal,

in favor of New York State Department of Health

as obligee, for the period BEGINNING 02/01/2019 and ENDING 02/01/2020,

subject to all terms and conditions of said bond; PROVIDED that the liability of The Ohio Casualty Insurance Company (Surety) shall not exceed in the aggregate the amount above written, whether the loss shall have occurred during the term of said bond or during any continuation or continuations thereof, or partly during the said term and partly during any continuation or continuations thereof.

Signed and Sealed this 9th day of January, 2019.

The Ohio Casualty Insurance Company (Surety)

BY: Pam Coleman

Attorney-In-Fact, Pam Coleman

SURETY CORPORATE SEAL

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS PRINTED ON RED BACKGROUND.
This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Certificate No. 8144682

Principal: Absolut Center for Nursing & Rehabilitation at Allegany, LLC

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

Bond Number 4036475

Obligee:
New York State Department of Health

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, Pam Coleman; Amanda Loveday; Charles C. Martin; Tara W. Mealer; Nikki Norman; James F. Oakes; Lavonne Sherrod

all of the city of Knoxville, state of TN each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations, in pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 3rd day of July, 2018.

The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

STATE OF PENNSYLVANIA ss
COUNTY OF MONTGOMERY

On this 3rd day of July, 2018, before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS – Section 12. Power of Attorney. Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts – SECTION 5. Surety Bonds and Undertakings. Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Renee C. Llewellyn, the undersigned, Assistant Secretary, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 9th day of January, 20 19.

By: _____
Renee C. Llewellyn, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

LMS_12873_022017

CONTINUATION CERTIFICATE

In consideration of the premium charged, The Ohio Casualty Insurance Company, as Surety,

hereby continues in force BOND NO. 4036469

in the amount of One Hundred Forty Thousand Dollars ($140,000.00),

on behalf of Absolut Center for Nursing & Rehabilitation at Aurora Park, LLC as Principal,

in favor of New York State Department of Health

as obligee, for the period BEGINNING 02/01/2019 and ENDING 02/01/2020,

subject to all terms and conditions of said bond; PROVIDED that the liability of The Ohio Casualty Insurance Company (Surety) shall not exceed in the aggregate the amount above written, whether the loss shall have occurred during the term of said bond or during any continuation or continuations thereof, or partly during the said term and partly during any continuation or continuations thereof.

Signed and Sealed this 9th day of January, 2019.

The Ohio Casualty Insurance Company (Surety)

BY: Pam Coleman

Attorney-In-Fact, Pam Coleman

SURETY CORPORATE SEAL

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS PRINTED ON RED BACKGROUND.
This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Certificate No. 8144682

Principal: **Absolut Center for Nursing & Rehabilitation at Aurora Park, LLC**

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

Bond Number 4036469

Obligee:
New York State Department of Health

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, Pam Coleman; Amanda Loveday; Charles C. Martin; Tara W. Mealer; Nikki Norman; James F. Oakes; Lavonne Sherrod

all of the city of Knoxville, state of TN each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations. In pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 3rd day of July, 2018.

The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

STATE OF PENNSYLVANIA ss
COUNTY OF MONTGOMERY

On this 3rd day of July, 2018, before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS – Section 12. Power of Attorney. Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts – SECTION 5. Surety Bonds and Undertakings. Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Renee C. Llewellyn, the undersigned, Assistant Secretary, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 9th day of January, 20 19.

By: _____
Renee C. Llewellyn, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

LMS_12873_022017

CONTINUATION CERTIFICATE

In consideration of the premium charged, The Ohio Casualty Insurance Company, as Surety,

hereby continues in force BOND NO. 4036476

in the amount of Thirty Thousand Dollars ($30,000.00),

on behalf of Absolut Center for Nursing & Rehabilitation at Gasport, LLC as Principal,

in favor of New York State Department of Health

as obligee, for the period BEGINNING 02/01/2019 and ENDING 02/01/2020,

subject to all terms and conditions of said bond; PROVIDED that the liability of The Ohio Casualty Insurance Company (Surety) shall not exceed in the aggregate the amount above written, whether the loss shall have occurred during the term of said bond or during any continuation or continuations thereof, or partly during the said term and partly during any continuation or continuations thereof.

Signed and Sealed this 9th day of January, 2019.

The Ohio Casualty Insurance Company (Surety)

BY: Pam Coleman

Attorney-In-Fact, Pam Coleman

SURETY CORPORATE SEAL

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS PRINTED ON RED BACKGROUND.
This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Certificate No. 8144682

Principal: Absolut Center for Nursing & Rehabilitation at Gasport, LLC

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

Bond Number 4036476

Obligee:
New York State Department of Health

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, Pam Coleman; Amanda Loveday; Charles C. Martin; Tara W. Mealer; Nikki Norman; James F. Oakes; Lavonne Sherrod

all of the city of Knoxville, state of TN each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations, in pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 3rd day of July, 2018.

The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

STATE OF PENNSYLVANIA ss
COUNTY OF MONTGOMERY

On this 3rd day of July, 2018, before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS – Section 12. Power of Attorney. Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts – SECTION 5. Surety Bonds and Undertakings. Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Renee C. Llewellyn, the undersigned, Assistant Secretary, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 9th day of January, 20 19

By: _____
Renee C. Llewellyn, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

CONTINUATION CERTIFICATE

In consideration of the premium charged, The Ohio Casualty Insurance Company, as Surety,

hereby continues in force BOND NO. 4036479

in the amount of Forty Five Thousand Dollars ($45,000.00),

on behalf of Absolut Center for Nursing & Rehabilitation at Orchard Brooke, LLC as Principal,

in favor of New York State Department of Health

as obligee, for the period BEGINNING 02/01/2019 and ENDING 02/01/2020,

subject to all terms and conditions of said bond; PROVIDED that the liability of The Ohio Casualty Insurance Company (Surety) shall not exceed in the aggregate the amount above written, whether the loss shall have occurred during the term of said bond or during any continuation or continuations thereof, or partly during the said term and partly during any continuation or continuations thereof.

Signed and Sealed this 9th day of January, 2019.

The Ohio Casualty Insurance Company (Surety)

BY: Pam Coleman

Attorney-In-Fact, Pam Coleman

SURETY CORPORATE SEAL

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS PRINTED ON RED BACKGROUND.
This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Certificate No. 8144682

Principal: Absolut at Orchard Brooke, LLC

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company West American Insurance Company

Bond Number 4036479

Obligee:
New York State Department of Health

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint,
Pam Coleman; Amanda Loveday; Charles C. Martin; Tara W. Mealer; Nikki Norman; James F. Oakes; Lavonne Sherrod

all of the city of Knoxville, state of TN each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations. In pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 3rd day of July, 2018.

The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

STATE OF PENNSYLVANIA ss
COUNTY OF MONTGOMERY

On this 3rd day of July, 2018, before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows.

ARTICLE IV – OFFICERS – Section 12. Power of Attorney. Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts – SECTION 5. Surety Bonds and Undertakings. Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Renee C. Llewellyn, the undersigned, Assistant Secretary, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 9th day of January, 20 19.

By: _____
Renee C. Llewellyn, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

LMS_12873_022017

CONTINUATION CERTIFICATE

In consideration of the premium charged, The Ohio Casualty Insurance Company, as Surety,

hereby continues in force BOND NO. 4036468

in the amount of One Hundred Thousand Dollars ($100,000.00),

on behalf of Absolut Center for Nursing & Rehabilitation at Orchard Park, LLC as Principal,

in favor of New York State Department of Health

as obligee, for the period BEGINNING 02/01/2019 and ENDING 02/01/2020,

subject to all terms and conditions of said bond; PROVIDED that the liability of The Ohio Casualty Insurance Company (Surety) shall not exceed in the aggregate the amount above written, whether the loss shall have occurred during the term of said bond or during any continuation or continuations thereof, or partly during the said term and partly during any continuation or continuations thereof.

Signed and Sealed this 9th day of January, 2019.

The Ohio Casualty Insurance Company (Surety)

BY: Pam Coleman

Attorney-In-Fact, Pam Coleman

SURETY CORPORATE SEAL

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS PRINTED ON RED BACKGROUND.
This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Certificate No. 8144682

Principal: Absolut Center for Nursing & Rehabilitation at Orchard Park, LLC

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

Bond Number 4036468

Obligee:
New York State Department of Health

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, Pam Coleman; Amanda Loveday; Charles C. Martin; Tara W. Mealer; Nikki Norman; James F. Oakes; Lavonne Sherrod

all of the city of Knoxville, state of TN each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations. In pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 3rd day of July, 2018.

The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

STATE OF PENNSYLVANIA ss
COUNTY OF MONTGOMERY

On this 3rd day of July, 2018, before me personally appeared David M Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS – Section 12. Power of Attorney. Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts – SECTION 5. Surety Bonds and Undertakings. Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Renee C. Llewellyn, the undersigned, Assistant Secretary, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 9th day of January, 20 19.

By: _____
Renee C. Llewellyn, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

LMS_12873_022017

CONTINUATION CERTIFICATE

In consideration of the premium charged, The Ohio Casualty Insurance Company, as Surety,

hereby continues in force BOND NO. 4036470

in the amount of Thirty Thousand Dollars ($30,000.00),

on behalf of Absolut Center for Nursing & Rehabilitation at Three Rivers, LLC as Principal,

in favor of New York State Department of Health

as obligee, for the period BEGINNING 02/01/2019 and ENDING 02/01/2020,

subject to all terms and conditions of said bond; PROVIDED that the liability of The Ohio Casualty Insurance Company (Surety) shall not exceed in the aggregate the amount above written, whether the loss shall have occurred during the term of said bond or during any continuation or continuations thereof, or partly during the said term and partly during any continuation or continuations thereof.

Signed and Sealed this 9th day of January, 2019.

The Ohio Casualty Insurance Company (Surety)

BY: Pam Coleman

Attorney-In-Fact, Pam Coleman

SURETY CORPORATE SEAL

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS PRINTED ON RED BACKGROUND.
This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Certificate No. 8144682

Principal: Absolut Center for Nursing & Rehabilitation at Three Rivers, LLC

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

Bond Number 4036470

Obligee:
New York State Department of Health

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, Pam Coleman; Amanda Loveday; Charles C. Martin; Tara W. Mealer; Nikki Norman; James F. Oakes; Lavonne Sherrod

all of the city of Knoxville, state of TN each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations, in pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 3rd day of July, 2018.

The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

STATE OF PENNSYLVANIA ss
COUNTY OF MONTGOMERY

On this 3rd day of July, 2018, before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS – Section 12. Power of Attorney. Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts – SECTION 5. Surety Bonds and Undertakings. Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Renee C. Llewellyn, the undersigned, Assistant Secretary, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 9th day of January, 20 19.

By: _____
Renee C. Llewellyn, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

LMS_12873_022017

CONTINUATION CERTIFICATE

In consideration of the premium charged, The Ohio Casualty Insurance Company, as Surety,

hereby continues in force BOND NO. 4036471

in the amount of Thirty Thousand Dollars ($30,000.00),

on behalf of *Absolut Center for Nursing & Rehabilitation at Westfield, LLC* as Principal,

in favor of New York State Department of Health

as obligee, for the period BEGINNING 02/01/2019 and ENDING 02/01/2020,

subject to all terms and conditions of said bond; PROVIDED that the liability of The Ohio Casualty Insurance Company (Surety) shall not exceed in the aggregate the amount above written, whether the loss shall have occurred during the term of said bond or during any continuation or continuations thereof, or partly during the said term and partly during any continuation or continuations thereof.

Signed and Sealed this 9th day of January, 2019.

The Ohio Casualty Insurance Company (Surety)

BY: Pam Coleman

Attorney-In-Fact, Pam Coleman

SURETY CORPORATE SEAL

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS PRINTED ON RED BACKGROUND.
This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Certificate No. 8144682

Principal: Absolut Center for Nursing & Rehabilitation at Westfield, LLC

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

Bond Number 4036471

Obligee:
New York State Department of Health

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, Pam Coleman; Amanda Loveday; Charles C. Martin; Tara W. Mealer; Nikki Norman; James F. Oakes; Lavonne Sherrod

all of the city of Knoxville, state of TN each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations, in pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 3rd day of July, 2018.

The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

STATE OF PENNSYLVANIA ss
COUNTY OF MONTGOMERY

On this 3rd day of July, 2018, before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

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By: _____
Renee C. Llewellyn, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

LMS_12873_022017

NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

INSURANCE CERTIFICATE -- FOR HIRE PASSENGER VEHICLE

154 GREAT AMERICAN INS CO

Policy Number
CAP1554288

Name & Address of Issuer
718-333-1155
Grandview Brokerage Inc.
1815 65th Street
Brooklyn, NY 11204

Effective Date: 08/01/2019, 12:01 a.m.
Expiration Date: 03/01/2020, 12:01 a.m.
(Not acceptable to obtain registration after 45 days from effective date.)

An authorized NEW YORK insurer certifies that it has issued a liability policy complying with Section 370 of the NEW YORK Vehicle and Traffic Law to:

ABSOLUT;FACILITIES MANAGEMENT
300 GLEED AVENUE
EAST AURORA NY 14052

Applicable with respect to the following Motor Vehicle:

Year	Make	Vehicle Identification Number	Seats
2016	FORD	1FDEE3FL2GDC19048	12

THIS ID CARD MUST BE CARRIED IN THE INSURED VEHICLE FOR PRODUCTION UPON DEMAND

WARNING: Any person who issues or produces an ID card knowing that an Owner's Policy of insurance is not in effect may be committing a misdemeanor. In addition, a person who presents an ID card if insurance is not in effect may be committing a misdemeanor.

The name of the registrant and the name of the insured must coincide.

REPLACEMENT VEHICLE NOTATION: DMV WILL ONLY PROCESS A VEHICLE CHANGE (RE-REGISTRATION) USING THE REPLACED VEHICLE'S CURRENT REGISTRATION.

FH-1

NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

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154 GREAT AMERICAN INS CO

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FH-1

FAX: Scanable Bar Code

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4. DMV will not accept a faxed ID card without a scanable barcode

C *11*03/11/19 CAP1554288-01

NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

INSURANCE CERTIFICATE - FOR HIRE PASSENGER VEHICLE

154 GREAT AMERICAN INSURANCE COMPANY

Name & Address of Issuer Great American Insurance,
301 E. 4th Street,
Cincinnati, OH 45202

An authorized NEW YORK insurer certifies that it has issued a liability policy complying with Section 370 of the NEW YORK Vehicle and Traffic Law to:

ABSOLUT;FACILITIES
MANAGEMENT;LLC
300 GLEED AVE
EAST AURORA, NY 14052

Policy Number
CAP1554288

Effective Date	Expiration Date
03/01/2019	03/01/2020
12:01 a.m.	12:01 a.m.

(Not acceptable to obtain registration after 45 days from effective date.)

Applicable with respect to the following Motor Vehicle:

2017 FORD 15
Year Make Seats
1FDVU4XG9HKA03107
Vehicle Identification Number

THIS ID CARD MUST BE CARRIED IN THE INSURED VEHICLE FOR PRODUCTION UPON DEMAND

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The name of the registrant and the name of the insured must coincide.

REPLACEMENT VEHICLE NOTATION: DMV WILL ONLY PROCESS A VEHICLE CHANGE (RE-REGISTRATION) USING THE REPLACED VEHICLE'S CURRENT REGISTRATION.

FH-1

NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

INSURANCE CERTIFICATE - FOR HIRE PASSENGER VEHICLE

154 GREAT AMERICAN INSURANCE COMPANY

Name & Address of Issuer Great American Insurance,
301 E. 4th Street,
Cincinnati, OH 45202

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ABSOLUT;FACILITIES
MANAGEMENT;LLC
300 GLEED AVE
EAST AURORA, NY 14052

Policy Number
CAP1554288

Effective Date	Expiration Date
03/01/2019	03/01/2020
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NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

INSURANCE CERTIFICATE - FOR HIRE PASSENGER VEHICLE

154 GREAT AMERICAN INSURANCE COMPANY

Name & Address of Issuer Great American Insurance,
301 E. 4th Street,
Cincinnati, OH 45202

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ABSOLUT;FACILITIES
MANAGEMENT;LLC
300 GLEED AVE
EAST AURORA, KY 14052

Policy Number
CAP1554288

Effective Date	Expiration Date
03/01/2019	03/01/2020
12:01 a.m.	12:01 a.m.

(Not acceptable to obtain registration after 45 days from effective date.)

Applicable with respect to the following Motor Vehicle:

2017 FORD 15
Year Make Seats
1FDVU4XG3HKA03104
Vehicle Identification Number

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The name of the registrant and the name of the insured must coincide.

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FR-1

NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

INSURANCE CERTIFICATE - FOR HIRE PASSENGER VEHICLE

154 GREAT AMERICAN INSURANCE COMPANY

Name & Address of Issuer Great American Insurance,
301 E. 4th Street,
Cincinnati, OH 45202

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ABSOLUT;FACILITIES
MANAGEMENT;LLC
300 GLEED AVE
EAST AURORA, KY 14052

Policy Number
CAP1554288

Effective Date	Expiration Date
03/01/2019	03/01/2020
12:01 a.m.	12:01 a.m.

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2017 FORD 15
Year Make Seats
1FDVU4XG3HKA03104
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NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

INSURANCE CERTIFICATE - FOR HIRE PASSENGER VEHICLE

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NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

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Policy Number
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Applicable with respect to the following Motor Vehicle:

2016 FORD 12
Year Make Seats
1FDEE3FL2GDC16277
Vehicle Identification Number

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MANAGEMENT;LLC
300 GLEED AVE
EAST AURORA, NY 14052

Policy Number
CAP1554288

Effective Date	Expiration Date
03/01/2019	03/01/2020
12:01 a.m.	12:01 a.m.

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Applicable with respect to the following Motor Vehicle:

2016 FORD 12
Year Make Seats

1FDEE3FL0GDC19047
Vehicle Identification Number

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FH-1

NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

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MANAGEMENT;LLC
300 GLEED AVE
EAST AURORA, NY 14052

Policy Number
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Year Make Seats

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NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

INSURANCE CERTIFICATE -- FOR HIRE PASSENGER VEHICLE

GREAT AMERICAN INSURANCE COMP

Policy Number
CAP1554288

Name & Address of Issuer
GRANDVIEW BROKERAGE CORP
1815-66TH STREET

BROOKLYN, NY 11204

Effective Date: 03/01/2019 12:01 a.m.
Expiration Date: 03/01/2020 12:01 a.m.
(Not acceptable to obtain registration after 45 days from effective date.)

An authorized NEW YORK insurer certifies that it has issued a liability policy complying with Section 370 of the NEW YORK Vehicle and Traffic Law to:

ABSOLUT;FACILITIES MANAGEMENT
300 GLEED AVENUE
EAST AURORA NY 14052

Applicable with respect to the following Motor Vehicle:

Year	Make	Vehicle Identification Number	Seats
2016	FORD	1FDEE3FLXGDC19041	12

THIS ID CARD MUST BE CARRIED IN THE INSURED VEHICLE FOR PRODUCTION UPON DEMAND

WARNING: Any person who issues or produces an ID card knowing that an Owner's Policy of Insurance is not in effect may be committing a misdemeanor. In addition, a person who presents an ID card if insurance is not in effect may be committing a misdemeanor.

The name of the registrant and the name of the insured must coincide.

REPLACEMENT VEHICLE NOTATION: DMV WILL ONLY PROCESS A VEHICLE CHANGE (RE-REGISTRATION) USING THE REPLACED VEHICLE'S CURRENT REGISTRATION.

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Year	Make		
2016	FORD		
Vehicle Identification Number			Seats
1FDEE3FL1GDC19039			12

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2008	CHEVY	1GBDV13W08D131124	6

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NEW YORK STATE INSURANCE IDENTIFICATION CARD

154 GREAT AMERICAN INS CO

Name & Address of Issuer
Grandview Brokerage Corp
1815 65th Street
Brooklyn, NY 11204

An authorized NEW YORK insurer has issued an Owner's Policy of Liability Insurance complying with Article 6 (Motor Vehicle Financial Security Act) of the NEW YORK Vehicle and Traffic Law to:

ABSOLUT;FACILITIES
MANAGEMENT
300 GLEED AVE
AURORA NY 14052

Policy Number
CAP 3878262-12

Effective Date	Expiration Date
08/09/2019	08/09/2020
12:01 a.m.	12:01 a.m.

(Not acceptable to obtain registration after 45 days from effective date.)

Applicable with respect to the following Motor Vehicle:

2015	TOYOT
Year	Make

JTDKN3DUXF0454600
Vehicle Identification Number

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FS-20

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5N1DR2MM2HC612156
Vehicle Identification Number

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KNMAT2MV9HP572975
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REPLACEMENT VEHICLE NOTATION: DMV WILL ONLY PROCESS A VEHICLE CHANGE (RE-REGISTRATION) USING THE REPLACED VEHICLE'S CURRENT REGISTRATION.

FS-20

FAX: Scanable Bar Code

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NEW YORK STATE INSURANCE IDENTIFICATION CARD

154 GREAT AMERICAN INS CO

Name & Address of Issuer Grandview Brokerage Corp
1815 65th Street
Brooklyn, NY 11204

An authorized NEW YORK insurer has issued an Owner's Policy of Liability Insurance complying with Article 6 (Motor Vehicle Financial Security Act) of the NEW YORK Vehicle and Traffic Law to:

ABSOLUT;FACILITIES
MANAGEMENT
300 GLEED AVE
AURORA NY 14052

Policy Number
CAP 3878262-12

Effective Date	Expiration Date
08/09/2019	08/09/2020
12:01 a.m.	12:01 a.m.

(Not acceptable to obtain registration after 45 days from effective date.)

Applicable with respect to the following Motor Vehicle:

Year	Make
2017	TOYOT

JTDKBRFU4H3576007
Vehicle Identification Number

THIS ID CARD MUST BE CARRIED IN THE INSURED VEHICLE FOR PRODUCTION UPON DEMAND

WARNING: Any person who issues or produces an ID card knowing that an Owner's Policy of insurance is not in effect may be committing a misdemeanor. In addition, a person who presents an ID card if insurance is not in effect may be committing a misdemeanor.

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1815 65th Street
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Year	Make
2017	TOYOT

JTDKBRFU3H3026166
Vehicle Identification Number

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Applicable with respect to the following Motor Vehicle:

Year	Make
2015	TOYOT

JTDKN3DU4F0456620
Vehicle Identification Number

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08/09/2019	08/09/2020
12:01 a.m.	12:01 a.m.

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Applicable with respect to the following Motor Vehicle:

2017	TOYOT
Year	Make

JTDKBRFU5H3039114
Vehicle Identification Number

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JTDKDTB36J1620126
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Applicable with respect to the following Motor Vehicle:

Year	Make
2019	CHEVR

1GNERFKW9KJ218832
Vehicle Identification Number

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2016	TOYOT
Year	Make

JTDKBRFU5G3511214
Vehicle Identification Number

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ABSOFAC-01 BKOHN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/10/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	PHONE (A/C, No, Ext): (718) 333-1155	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Executive Risk Indemnity INC	35181
INSURED	INSURER B :	
Absolut Facilities Management 300 Gleed Avenue East Aurora, NY 14052-2983	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO							
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per person)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Directors & Officers			8243-6187	8/24/2019	8/24/2020	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Facilities Management, LLC
300 Gleed Avenue
East Aurora, NY 14052

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schwarz

ABSOFAC-01 BKOHN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/10/2019

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	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Executive Risk Indemnity INC	35181
INSURED Absolut Center for Nursing and Rehabilitation at Allegany, LLC 2178 North Fifth Street Allegany, NY 14706	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Directors & Officers			8243-6125	8/24/2019	8/24/2020	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Allegany, LLC
2178 North Fifth Street
Allegany, NY 14706

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schumacher

ABSOFAC-01 BKOHN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/10/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	CONTACT NAME: PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Executive Risk Indemnity INC	35181
INSURED Absolut Center for Nursing and Rehabilitation at Aurora Park, LLC 292 Main Street East Aurora, NY 14052	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Directors & Officers			8243-6134	8/24/2019	8/24/2020	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

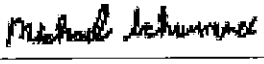
CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Aurora Park, LLC
292 Main Street
East Aurora, NY 14052

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



ACORD 25 (2016/03)

ABSOFAC-01 BKOHN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/10/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	CONTACT NAME: PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Executive Risk Indemnity INC	35181
INSURED Absolut Center for Nursing and Rehabilitation at Gasport, LLC 4540 Lincoln Drive Gasport, NY 14067	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Directors & Officers			8243-6170	8/24/2019	8/24/2020	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Gasport, LLC
4540 Lincoln Drive
Gasport, NY 14067

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schwimmer

ABSOFAC-01 BKOHN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/10/2019

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PRODUCER	CONTACT NAME:	
Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	PHONE (A/C, No, Ext): (718) 333-1155	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Executive Risk Indemnity INC	35181
INSURED	INSURER B :	
Absolut at Orchard Brooke LLC 6060 Armor Road Orchard Park, NY 14127	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Directors & Officers			8243-6118	8/24/2019	8/24/2020	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut at Orchard Brooke LLC
6060 Armor Road
Orchard Park, NY 14127

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schumer

ABSOFAC-01 BKOHN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/10/2019

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PRODUCER
Grandview Brokerage Corp
1815-65th Street
Brooklyn, NY 11204

CONTACT NAME:
PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Executive Risk Indemnity INC	35181
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Absolut Center for Nursing and Rehabilitation at Orchard Park LLC
6060 Armor Road Drive
Orchard Park, NY 14127

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N / A						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Directors & Officers			8243-6172	8/24/2019	8/24/2020	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Orchard Park LLC
6060 Armor Road
Orchard Park, NY 14127

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schumacher

ACORD

ABSOFAC-01 BKOHN

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/10/2019

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PRODUCER	CONTACT NAME:	
Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	PHONE (A/C, No, Ext): (718) 333-1155	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Executive Risk Indemnity INC	35181
INSURED	INSURER B :	
Absolut Facilities Management 300 Gleed Avenue East Aurora, NY 14052-2983	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Directors & Officers			8243-6180	8/24/2019	8/24/2020	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Three Rivers LLC
101 Creekside Drive
Painted Post, NY 14870

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schumacher

ABSOFAC-01 BKOHN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/10/2019

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PRODUCER Grandview Brokerage Corp 1815-65th Street Brooklyn, NY 11204	CONTACT NAME: PHONE (A/C, No, Ext): (718) 333-1155 FAX (A/C, No): E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Executive Risk Indemnity INC	35181
INSURED Absolut Center for Nursing and Rehabilitation at Westfield, LLC 26 Cass Street Westfield, NY 14787	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Directors & Officers			8243-6185	8/24/2019	8/24/2020	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Absolut Center for Nursing and Rehabilitation at Westfield, LLC
26 Cass Street
Westfield, NY 14787

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Michael Schumacher

ACORD 25 (2016/03)

From: Ed Sims [ESIMS@tisins.com]
Sent: Friday, October 11, 2019 11:40 AM
To: Hoffman, Phil
Cc: Hayli Dunn; Ed Sims
Subject: Absolut Facilities Management, LLC

Phil,

We have received your request to provide a certificate of insurance for Crime Policy # 82234980, along with the completed Attachment B, indicating United States Trustee as Additional Notified Party. We have submitted this request to our Crime insurance carrier and have received the following response.

Additional Notified Party is not a pre-existing form that can be endorsed to the Crime policy. This request will need to be submitted to Federal Insurance Company / Chubb's in house legal department for review, which could take approximately two weeks. We have requested our carrier to begin this process and will advise of their decision as soon as possible.

Regarding the Patient Trust Bonds, Liberty Mutual has advised that they do not believe this request is applicable to surety bonds. However, the request is currently being reviewed to see if this is something they can provide. We will advise of their decision upon receipt.

We are working to do all that we can to comply with this request, and will hopefully have an answer to you soon.

Thank you,

Edward B. Sims, CIC
Chief Executive Officer

TIS Insurance Services, Inc.
1900 N. Winston Road, Suite 100
Knoxville, TN 37919
Learn more at TISins.com

o: 865.470.3710 m: 865.567.3288
f: 865.824.3910

M&T Bank
Understanding what's important®

October 21, 2019

To whom it may concern:

We are in the process of converting accounts enumerated in the September 11, 2019 notice for Absolute Facilities Management LLC, et al #19-76260 to "Debtor in Posession".

TITLE	NUMBER	TIN
ABSOLUT AT ALLEGANY LLC	[redacted]	208467875
ABSOLUT AT AURORA PARK LL		208468266
ABSOLUT AT GASPORT LLC		208468080
ABSOLUT AT GASPORT, LLC		208468080
ABSOLUT AT GASPORT, LLC		208468080
ABSOLUT AT ORCHARD PARK L		208468300
ABSOLUT AT THREE RIVERS L		208468133
ABSOLUT AT THREE RIVERS L		208468133
ABSOLUT AT THREE RIVERS L		208468133
ABSOLUT AT WESTFIELD LLC		208467924
ABSOLUT FACILITIES MANAGE		208471412
ABSOLUT FACILITIES MANAGE		208471412
ABSOLUT FACILITIES MANAGE		208471412
ABSOLUT FACILITIES MANAGE		208471412
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ABSOLUT FACILITIES MANAGE		208471412
ABSOLUT FACILITIES MANAGE		208471412
ABSOLUT FACILITIES MANAGE		208471412

Our Account Services area has an anticipated completion date of end of business October 25, 2019.

Sincerely,

Michael J. Wald
Banking Officer | Senior Relationship Liaison
One Fountain Plaza 12th Floor
Buffalo, NY 14203
716-848-7354|mwald@mtb.com

In re Absolut Facilities Management, LLC, *et al.*
Debtor

Case No. 19-76260 (AST) (Jointly Administered)

CASH FLOW PROJECTIONS FOR THE 12 MONTH PERIOD: _____ through _____

This schedule must be filed with the Court and a copy submitted to the United States Trustee within 20 days after the order for relief. Amended cash flow projections should be submitted as necessary.

	Month	Month	Month	Month	Month	Month	Month	Month	Month	Month	Month	Month	Total
Cash Beginning of Month													
RECEIPTS													
CASH SALES													
ACCOUNTS RECEIVABLE													
LOANS AND ADVANCES													
SALE OF ASSETS													
OTHER *(ATTACH LIST)*													
TOTAL RECEIPTS													
DISBURSEMENTS													
NET PAYROLL													
PAYROLL TAXES													
SALES, USE, AND OTHER TAXES													
INVENTORY PURCHASES													
SECURED/ RENTAL/ LEASES													
INSURANCE													
ADMINISTRATIVE & SELLING													
OTHER *(ATTACH LIST)*													
PROFESSIONAL FEES													
U.S. TRUSTEE FEES													
COURT COSTS													
TOTAL DISBURSEMENTS													
NET CASH FLOW (RECEIPTS LESS DISBURSEMENTS)													
Cash End of Month													

See attached forms.

Subject to On-going Change

Absolut Facilities Management
Cash Projection - Consolidated

Week Ended:	1 10/18/19	2 10/25/19	3 11/01/19	4 11/08/19	5 11/15/19	6 11/22/19	7 11/29/19	8 12/06/19	9 12/13/19	10 12/20/19	11 12/27/19	12 01/03/20	13 01/10/20	**10/18/19 - 01/10/20** TOTAL
Opening Cash Balance	$ 1,870,730	$ 1,432,724	$ 1,867,779	$ 1,662,381	$ 899,251	$ 57,744	$ 334,223	$ 837,553	$ 52,201	$ 57,589	$ 58,069	$ 265,812	$ 59,100	$ 1,870,730
Anticipated D P Funding	-	-	-	-	(720,000)	(99,000)	-	520,000	270,000	(510,000)	(280,000)	1,140,000	290,000	611,000
Receipts														
Medicare	$ 54,424	$ 509,324	$ -	$ -	$ 54,424	$ -	$ 454,900	$ -	$ 54,424	$ -	$ 454,900	$ -	$ 54,424	1,636,820
Medicaid	518,819	395,273	183,502	341,288	378,788	378,788	283,688	358,616	378,788	378,788	317,488	358,616	378,788	4,651,230
Insurance, Self Pay	764,854	1,058,628	1,036,278	718,860	946,841	1,058,644	1,009,578	739,032	894,680	1,058,644	925,778	689,032	860,680	11,761,527
Miscellaneous	(119 548)	(147 238)	(25 000)	-	-	-	-	-	-	-	-	-	-	(291 786)
Total Receipts	1,218,549	1,815,987	1,194,780	1,060,148	1,380,053	1,437,432	1,748,166	1,097,648	1,327,892	1,437,432	1,698,166	1,047,648	1,293,892	17,757,791
Disbursements														
Payroll/ Taxes	809,262	691,535	697,759	703,982	710,205	716,429	716,429	716,429	716,429	716,429	716,429	716,429	716,429	9,344,178
Insurance	95,221	-	93,005	108,020	-	-	93,005	108,020	-	-	93,005	108,020	-	698,296
Pharmacy	28,301	28,301	28,301	28,301	28,301	28,301	28,301	28,301	28,301	28,301	28,301	28,301	28,301	367,913
Utilities	72,968	-	-	-	72,968	-	-	-	55,468	-	-	-	72,331	273,735
Food	31,520	31,520	31,520	31,520	31,520	31,520	31,520	31,520	31,520	31,520	31,520	31,520	31,520	409,760
Supplies	36,358	36,358	36,358	36,358	36,358	36,358	36,358	36,358	36,358	36,358	36,358	36,358	36,358	472,654
Vendors	111,413	111,413	111,413	111,413	111,413	111,413	111,413	111,413	111,413	111,413	111,413	111,413	111,413	1,448,369
Assessment (paid monthly - 15th)	202,904	-	-	-	246,643	-	-	-	238,863	-	-	-	238,863	927,273
Back Office Support - Payroll	123,968	-	123,968	-	98,636	-	98,636	-	98,636	-	98,636	-	98,636	741,118
Back Office Support-Rent/Phone/Con Svc/Other	19,639	3,710	19,639	3,710	15,515	2,931	15,515	2,931	15,515	2,931	15,515	2,931	15,515	135,999
Rent	-	300,000	-	799,974	-	-	-	799,974	-	-	-	799,974	-	2,699,922
Medical Claims Funding	125,000	-	-	-	125,000	-	-	-	125,000	-	-	-	125,000	500,000
Capital Lease on AP Renovation	-	-	79,245	-	-	-	79,245	-	-	-	79,245	-	-	237,736
Total Operating Disbursements	1,656,555	1,202,837	1,221,209	1,823,278	1,476,560	926,952	1,210,423	1,834,946	1,457,504	926,952	1,210,423	1,834,946	1,474,367	18,256,954
Operating Cash Flow	(438,006)	613,150	(26,429)	(763,130)	(96,507)	510,480	537,743	(737,298)	(129,612)	510,480	487,743	(787,298)	(180,475)	(499,163)
Utility Deposit - All Buildings	-	61,000	-	-	-	-	-	-	-	-	-	-	-	61,000
First day Relief	-	81,095	-	-	-	-	-	-	-	-	-	-	-	81,095
Debtor	-	-	-	-	-	-	-	439,000	-	-	-	400,000	-	839,000
Ombudsman	-	-	-	-	-	-	-	50,000	-	-	-	50,000	-	100,000
Lender	-	-	135,000	-	-	135,000	-	-	110,000	-	-	-	110,000	490,000
UCC	-	-	-	-	-	-	-	75,000	-	-	-	75,000	-	150,000
Chapter 11 Fees	-	36,000	-	-	-	-	-	-	-	-	-	-	-	36,000
Adequate Protection	-	-	34,413				34,413	-	-	-	-	34,413		103,240
DIP Interest & Fees	-	-	9,555	-	25,000	-	-	4,053	25,000	-	-	-	-	63,608
														-
Total Restructuring Disbursements	-	178,095	178,968	-	25,000	135,000	34,413	568,053	135,000	-	-	559,413	110,000	1,923,943
Cash Flow	(438,006)	435,055	(205,397)	(763,130)	(121,507)	375,480	503,330	(1,305,351)	(264,612)	510,480	487,743	(1,346,712)	(290,475)	(2,423,106)
Beginning Cash Balance	$ 1,870,730	$ 1,432,724	$ 1,867,779	$ 1,662,381	$ 899,251	$ 57,744	$ 334,223	$ 837,553	$ 52,201	$ 57,589	$ 58,069	$ 265,812	$ 59,100	$ 1,870,730
Cash Flow	(438,006)	435,055	(205,397)	(763,130)	(121,507)	375,480	503,330	(1,305,351)	(264,612)	510,480	487,743	(1,346,712)	(290,475)	(2,423,106)
Borrowing / (Repayment)	-	-	-	-	(720,000)	(99,000)	-	520,000	270,000	(510,000)	(280,000)	1,140,000	290,000	611,000
Ending Cash Balance	$ 1,432,724	$ 1,867,779	$ 1,662,381	$ 899,251	$ 57,744	$ 334,223	$ 837,553	$ 52,201	$ 57,589	$ 58,069	$ 265,812	$ 59,100	$ 58,625	$ 58,625

$ 1,140,000

Subject to On-going Change

Cash Projection - Aurora Park

	1 10/11/19	2 10/18/19	3 10/25/19	4 11/1/19	5 11/8/19	6 11/15/19	7 11/22/19	8 11/29/19	9 12/6/19	10 12/13/19	11 12/20/19	12 12/27/19	13 1/3/20	TOTAL
Incoming Cash:														
Medicare	$ -	$ 28,000	$ 160,000	$ -	$ -	$ 28,000	$ -	$ 132,000	$ -	$ 28,000	$ -	$ 132,000	$ -	$ 508,000
Medicaid	192,290	195,629	151,484	106,902	203,788	241,288	241,288	156,488	241,383	241,288	241,288	190,288	241,383	2,644,787
Insurance, Self Pay	115,308	487,370	478,916	360,126	211,598	537,215	496,557	373,926	211,503	537,215	496,557	340,126	211,503	4,857,916
Miscellaneous	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	307,598	710,999	790,400	467,028	415,386	806,503	737,845	662,414	452,886	806,503	737,845	662,414	452,886	8,010,703
Outgoing Cash:														
Payroll/ Taxes	336,211	330,037	336,260	342,484	348,707	354,930	361,154	361,154	361,154	361,154	361,154	361,154	361,154	4,576,707
Insurances	71,512	-	-	-	71,512	-	-	-	71,512	-	-	-	71,512	286,048
pharmacy	14,015	14,015	14,015	14,015	14,015	14,015	14,015	14,015	14,015	14,015	14,015	14,015	14,015	182,195
utilities	-	27,368	-	-	-	27,368	-	-	-	27,368	-	-	-	82,104
food	14,085	14,085	14,085	14,085	14,085	14,085	14,085	14,085	14,085	14,085	14,085	14,085	14,085	183,105
supplies	15,561	15,561	15,561	15,561	15,561	15,561	15,561	15,561	15,561	15,561	15,561	15,561	15,561	202,293
Vendors	48,976	48,976	48,976	48,976	48,976	48,976	48,976	48,976	48,976	48,976	48,976	48,976	48,976	636,688
Assessment (paid monthly - 15th)	-	70,667	-	-	-	113,863	-	-	-	113,863	-	-	-	298,393
Back Office Support - Payroll	-	40,130	-	40,130	-	40,130	-	40,130	-	40,130	-	40,130	-	240,781
Back Office Support-Rent/Phone/Con Svc/O	1,234	6,533	1,234	6,533	1,234	6,533	1,234	6,533	1,234	6,533	1,234	6,533	1,234	47,836
Rent	-	-	-	-	382,744	-	-	-	382,744	-	-	-	382,744	1,148,232
Capital Lease on AP Renovation	-	-	-	79,245	-	-	-	79,245	-	-	-	79,245	-	237,736
	501,594	567,372	430,131	561,029	896,834	635,461	455,025	579,699	909,281	641,685	455,025	579,699	909,281	8,122,118
Weekly Excess/(Shortfall) Cash	(193,996)	143,627	360,269	(94,002)	(481,448)	171,042	282,820	82,714	(456,395)	164,818	282,820	82,714	(456,395)	(111,414)
Cumulative Excess/(Shortfall) Cash	(193,996)	(50,369)	309,899	215,898	(265,551)	(94,509)	188,311	271,025	(185,371)	(20,553)	262,267	344,981	(111,414)	

Subject to On-going Change

Cash Projection - Orchard Park

Week of:	1 10/11/19	2 10/18/19	3 10/25/19	4 11/01/19	5 11/08/19	6 11/15/19	7 11/22/19	8 11/29/19	9 12/06/19	10 12/13/19	11 12/20/19	12 12/27/19	13 01/03/20	TOTAL
Incoming Cash:														
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medicaid	75,533	43,548	90,238	25,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	378,319
Insurance, Self Pay	31,281	76,000	57,000	-	-	-	-	-	-	-	-	-	-	164,281
Miscellaneous	(96,133)	(119,548)	(147,238)	(25,000)	-	-	-	-	-	-	-	-	-	(387,919)
	10,681	-	-	-	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	154,681
Outgoing Cash:														
Payroll/ Taxes	107,894	123,950	-	-	-	-	-	-	-	-	-	-	-	231,844
Insurances	44,244	-	-	-	44,244	-	-	-	44,244	-	-	-	44,244	176,976
pharmacy	-	-	-	-	-	-	-	-	-	-	-	-	-	-
utilities	-	17,500	-	-	-	17,500	-	-	-	-	-	-	-	35,000
food	-	-	-	-	-	-	-	-	-	-	-	-	-	-
supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vendors	18,675	-	-	-	-	-	-	-	-	-	-	-	-	18,675
Assessment (paid monthly - 15th)	-	48,904	-	-	-	7,780	-	-	-	-	-	-	-	56,684
Back Office Support - Payroll	-	25,332	-	25,332	-	-	-	-	-	-	-	-	-	50,664
Back Office Support-Rent/Phone/Con Svc/O	779	4,124	779	4,124	779	-	-	-	-	-	-	-	-	10,585
Rent				-				-	-	-		-	-	-
	171,592	219,810	779	29,456	45,023	25,280	-	-	44,244	-	-	-	44,244	580,428
Weekly Excess/(Shortfall) Cash	(160,911)	(219,810)	(779)	(29,456)	(29,023)	(9,280)	16,000	16,000	(28,244)	16,000	16,000	16,000	(28,244)	(425,746)
Cumulative Excess/(Shortfall) Cash	(160,911)	(380,721)	(381,500)	(410,956)	(439,978)	(449,258)	(433,258)	(417,258)	(445,502)	(429,502)	(413,502)	(397,502)	(425,746)	

Subject to On-going Change

Cash Projection - Three Rivers

	1 10/11/19	2 10/18/19	3 10/25/19	4 11/01/19	5 11/08/19	6 11/15/19	7 11/22/19	8 11/29/19	9 12/06/19	10 12/13/19	11 12/20/19	12 12/27/19	13 01/03/20	TOTAL
Incoming Cash:														
Medicare	$ -	$ 12,100	$ 168,000	$ -	$ -	$ 12,100	$ -	$ 155,900	$ -	$ 12,100	$ -	$ 155,900	$ -	$ 516,100
Medicaid	52,270	102,897	51,293	15,000	42,000	42,000	42,000	27,000	33,139	42,000	42,000	27,000	33,139	551,738
Insurance, Self Pay	203,099	39,598	4,621	240,599	213,369	100,495	106,914	147,699	222,230	100,495	106,914	147,699	222,230	1,855,963
Miscellaneous	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	255,369	154,595	223,914	255,599	255,369	154,595	148,914	330,599	255,369	154,595	148,914	330,599	255,369	2,923,801
Outgoing Cash:														
Payroll/ Taxes	111,381	111,381	111,381	111,381	111,381	111,381	111,381	111,381	111,381	111,381	111,381	111,381	111,381	1,447,953
Insurances	25,838				25,838				25,838				25,838	103,352
pharmacy	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	61,906
utilities		8,108				8,108				8,108				24,324
food	4,854	4,854	4,854	4,854	4,854	4,854	4,854	4,854	4,854	4,854	4,854	4,854	4,854	63,102
supplies	7,004	7,004	7,004	7,004	7,004	7,004	7,004	7,004	7,004	7,004	7,004	7,004	7,004	91,052
Vendors	14,644	14,644	14,644	14,644	14,644	14,644	14,644	14,644	14,644	14,644	14,644	14,644	14,644	190,372
Assessment (paid monthly - 15th)	-	28,667				43,000				43,000				114,667
Back Office Support - Payroll	-	15,049	-	15,049	-	15,049	-	15,049	-	15,049	-	15,049	-	90,292
Back Office Support-Rent/Phone/Con Svc/Otl	463	2,450	463	2,450	463	2,450	463	2,450	463	2,450	463	2,450	463	17,939
Rent				-	161,513			-	161,513				161,513	484,539
	168,946	196,918	143,108	160,144	330,459	211,252	143,108	160,144	330,459	211,252	143,108	160,144	330,459	2,689,498
Weekly Excess/(Shortfall) Cash	86,423	(42,323)	80,806	95,456	(75,090)	(56,656)	5,806	170,456	(75,090)	(56,656)	5,806	170,456	(75,090)	234,303
Cumulative Excess/(Shortfall) Cash	86,423	44,101	124,906	220,362	145,272	88,616	94,422	264,877	189,788	133,132	138,937	309,393	234,303	

Subject to On-going Change

Cash Projection - Westfield

	1 10/11/19	2 10/18/19	3 10/25/19	4 11/01/19	5 11/08/19	6 11/15/19	7 11/22/19	8 11/29/19	9 12/06/19	10 12/13/19	11 12/20/19	12 12/27/19	13 01/03/20	TOTAL
Incoming Cash:														
Medicare	$ -	$ 10,100	$ 103,600	$ -	$ -	$ 10,100	$ -	$ 93,500	$ -	$ 10,100	$ -	$ 93,500	$ -	$ 320,900
Medicaid	34,103	32,893	52,425	20,000	43,000	43,000	43,000	45,000	39,769	43,000	43,000	45,000	39,769	523,959
Insurance, Self Pay	45,767	44,261	336,862	187,467	36,870	34,154	256,387	262,467	40,101	34,154	256,387	262,467	40,101	1,837,450
Miscellaneous	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	79,870	87,254	492,887	207,467	79,870	87,254	299,387	400,967	79,870	87,254	299,387	400,967	79,870	2,682,309
Outgoing Cash:														
Payroll/ Taxes	99,809	99,809	99,809	99,809	99,809	99,809	99,809	99,809	99,809	99,809	99,809	99,809	99,809	1,297,517
Insurances	23,350				23,350				23,350				23,350	93,400
pharmacy	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	4,762	61,906
utilities		5,956				5,956				5,956				17,868
food	4,777	4,777	4,777	4,777	4,777	4,777	4,777	4,777	4,777	4,777	4,777	4,777	4,777	62,101
supplies	5,431	5,431	5,431	5,431	5,431	5,431	5,431	5,431	5,431	5,431	5,431	5,431	5,431	70,603
Vendors	16,208	16,208	16,208	16,208	16,208	16,208	16,208	16,208	16,208	16,208	16,208	16,208	16,208	210,704
Assessment (paid monthly - 15th)	-	26,667				40,000				40,000				106,667
Back Office Support - Payroll	-	15,049	-	15,049	-	15,049	-	15,049	-	15,049	-	15,049	-	90,292
Back Office Support-Rent/Phone/Con Svc/O	463	2,450	463	2,450	463	2,450	463	2,450	463	2,450	463	2,450	463	17,939
Rent				-	88,483			-	88,483				88,483	265,449
	154,800	181,108	131,450	148,486	243,283	194,442	131,450	148,486	243,283	194,442	131,450	148,486	243,283	2,294,446
Weekly Excess/(Shortfall) Cash	(74,930)	(93,854)	361,438	58,982	(163,413)	(107,187)	167,938	252,482	(163,413)	(107,187)	167,938	252,482	(163,413)	387,863
Cumulative Excess/(Shortfall) Cash	(74,930)	(168,783)	192,654	251,636	88,224	(18,963)	148,974	401,456	238,044	130,856	298,794	551,276	387,863	

Subject to On-going Change

Cash Projection - Allegany

	1 10/11/19	2 10/18/19	3 10/25/19	4 11/01/19	5 11/08/19	6 11/15/19	7 11/22/19	8 11/29/19	9 12/06/19	10 12/13/19	11 12/20/19	12 12/27/19	13 01/03/20	TOTAL
Incoming Cash:														
Medicare		$ 700	$ 49,200			$ 700		$ 48,500		$ 700		$ 48,500		$ 148,300
Medicaid	8,047	58,188	10,990	1,600	8,500	8,500	8,500	7,200	6,422	8,500	8,500	7,200	6,422	148,569
Insurance, Self Pay	10,487	20,563	56,653	55,857	10,034	70,251	59,843	50,257	12,112	70,251	59,843	50,257	12,112	538,523
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	18,534	79,451	116,843	57,457	18,534	79,451	68,343	105,957	18,534	79,451	68,343	105,957	18,534	835,392
Outgoing Cash:														
Payroll/ Taxes	37,830	37,830	37,830	37,830	37,830	37,830	37,830	37,830	37,830	37,830	37,830	37,830	37,830	491,790
Insurances	7,964				7,964				7,964				7,964	31,856
pharmacy	1,468	1,468	1,468	1,468	1,468	1,468	1,468	1,468	1,468	1,468	1,468	1,468	1,468	19,084
utilities		2,892				2,892				2,892				8,676
food	1,613	1,613	1,613	1,613	1,613	1,613	1,613	1,613	1,613	1,613	1,613	1,613	1,613	20,969
supplies	1,853	1,853	1,853	1,853	1,853	1,853	1,853	1,853	1,853	1,853	1,853	1,853	1,853	24,089
Vendors	5,920	5,920	5,920	5,920	5,920	5,920	5,920	5,920	5,920	5,920	5,920	5,920	5,920	76,960
Assessment (paid monthly - 15th)		9,333				14,000				14,000				37,333
Back Office Support - Payroll	0	4,640	0	4,640	0	4,640	0	4,640	0	4,640	0	4,640	0	27,841
Back Office Support-Rent/Phone/Con Svc/O	143	755	143	755	143	755	143	755	143	755	143	755	143	5,531
Rent				0	47,196			0	47,196				47,196	141,588
	56,791	66,305	48,827	54,080	103,987	70,972	48,827	54,080	103,987	70,972	48,827	54,080	103,987	885,717
Weekly Excess/(Shortfall) Cash	(38,256)	13,147	68,016	3,377	(85,452)	8,480	19,516	51,877	(85,452)	8,480	19,516	51,877	(85,452)	(50,325)
Cumulative Excess/(Shortfall) Cash	(38,256)	(25,110)	42,907	46,284	(39,168)	(30,688)	(11,172)	40,706	(44,747)	(36,267)	(16,750)	35,127	(50,325)	

Subject to On-going Change

Cash Projection - Gasport

	1 10/11/19	2 10/18/19	3 10/25/19	4 11/01/19	5 11/08/19	6 11/15/19	7 11/22/19	8 11/29/19	9 12/06/19	10 12/13/19	11 12/20/19	12 12/27/19	13 01/03/20	TOTAL
Incoming Cash:														
Medicare		$ 3,524	$ 28,524			$ 3,524		$ 25,000		$ 3,524		$ 25,000		$ 89,096
Medicaid	66,966	85,664	38,843	15,000	28,000	28,000	28,000	32,000	21,903	28,000	28,000	32,000	21,903	454,279
Insurance, Self Pay	70,466	82,864	95,427	121,757	109,432	140,528	109,794	104,757	115,529	140,528	109,794	104,757	115,529	1,421,160
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	-
	137,432	172,052	162,794	136,757	137,432	172,052	137,794	161,757	137,432	172,052	137,794	161,757	137,432	1,964,535
Outgoing Cash:														
Payroll/ Taxes	82,132	82,132	82,132	82,132	82,132	82,132	82,132	82,132	82,132	82,132	82,132	82,132	82,132	1,067,716
Insurances	17,489				17,489				17,489				17,489	69,956
pharmacy	3,294	3,294	3,294	3,294	3,294	3,294	3,294	3,294	3,294	3,294	3,294	3,294	3,294	42,822
utilities		5,616				5,616				5,616				16,848
food	3,172	3,172	3,172	3,172	3,172	3,172	3,172	3,172	3,172	3,172	3,172	3,172	3,172	41,236
supplies	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	45,864
Vendors	15,227	15,227	15,227	15,227	15,227	15,227	15,227	15,227	15,227	15,227	15,227	15,227	15,227	197,951
Assessment (paid monthly - 15th)	0	18,667				28,000				28,000				74,667
Back Office Support - Payroll	0	12,103	0	12,103	0	12,103	0	12,103	0	12,103	0	12,103	0	72,618
Back Office Support-Rent/Phone/Con Svc/O	320	1,694	320	1,694	320	1,694	320	1,694	320	1,694	320	1,694	320	12,407
Rent				0	46,208			0	46,208				46,208	138,624
	125,162	145,433	107,673	121,150	171,370	154,766	107,673	121,150	171,370	154,766	107,673	121,150	171,370	1,780,708
Weekly Excess/(Shortfall) Cash	12,270	26,619	55,121	15,606	(33,938)	17,286	30,121	40,606	(33,938)	17,286	30,121	40,606	(33,938)	183,827
Cumulative Excess/(Shortfall) Cash	12,270	38,889	94,010	109,616	75,678	92,963	123,084	163,691	129,752	147,038	177,159	217,765	183,827	